Falls management consensus group

Are all falls for care home residents preventable?

not all falls are preventable, able to reduce risk, there will always been a situation where you have done everything mostly, but not all falls. lots of falls can be prevented but not all. there's always a situation out of our control

no, in the care homes are the oldest and most frail members of the population with multiple pathologies agree with others, not all preventable. training for the falls prevention give people the wrong idea and sets people up to fail. we can reduce risk and can affect falls frequency. but there will always be need for continual need. preventable is the wrong word to use with care home residents who have complex needs. its gives the wrong idea to others

again, it is about mitigating risk, caring for the most vulnerable in our community, its why they are in a care home. is preventable the right word?

no falls will occur, and its about managing risk and optimising residents status of risk.

no i dont think all falls can be prevented. residents will fall even if we wrap them in bubble wrap they will fall. preventable is the wrong terminology

use avoidable and unavoidable rather than preventable. mainly due to difficulties with family members, sometime cant be avoided.
agreement with other. not all preventable. preventable implies failure if a fall occurs. can do everything, people have multiple pathologies. need to bring families along

*language - avoidable support staff engagement

* avoidable sets expectations too high. long term frequent fallers, reduced every risk, but they continue to walk, may have challenging behaviour which increases falls risk. terminology for the most frail and most complex needed who have had holistic assessment.

* preventable and managing falls. some residents you will be actively preventing a fall. and other who need review, and the conclusion is that they are managed. this doesn't stop a risk assessment process. what are we asking, is it more about falls risks? this feels more feasible

*risk reduction and mitigation support managing expectations

* sometimes when you’ve already reduced every risk factor. plan shifts from risk of falls to risk of injury. there is a risk of labelling patients, and these patients will still require Ix. eg constipation / infection etc

*** language of preventable is challenging. remains important to look at everything post fall. Risk reduction and need to be proactive

How can falls management programmes balance supporting residents to be active alongside managing potential risks?

positive risk assessment, you can restrict people too much, enable I and QOL

training - from PT and OT re exercises and mobility supported falls management in the community, care homes can be lacking here
balance the potential to be active. need to be proactive with someone activity. organise their chance to be active, schedule it in. Make every movement count, so that you not just telling people to sit down

exercise programmes, improving gait, enabling I through equipment eg frames, grab rails. manging balance gait in order to maximise and manage independence for as long a possible. residents want to be indep but abilities increase falls risk

stood out from an OT perspective, care vs ability to empower, sometimes the culture, care could be flipped on its head to support empowering. eg physically lifting a foot onto a foot plate. can we input subtly things into practice. meaningful engagement to promote physical ability without labelling it as falls prevention - does this put added pressure on individuals. what approach is put into play, can use compensatory approach eg aids / equipment to be Indep, but this isnt tackling the route cause, do we need to look at biomechanical approach to maintain indep for longer

making it part of the routine, eg schemes where car ehome staff have training to support structured activity sessions, but also other ADL eg walking to dinning room. need individualised approach, and different options available. eg those who need full support and some will choose and activity. not a rehab or therapeutic intervention but bread and butter

collaborative approach, resident as an individual, medical problems, mobility problems and looking at the environment. eg depth perception and the carpet in their room doesnt help. include the resident in this conversation. eg exercise regime or nutrition, if the person doesnt want to be involved then need to take +ve risk to minimise injury

whats the definition of falls management? risk associated with not moving, vs risk associated with moving. is the person in a position that they can be rehabilitated or are they in a place of palliation. can also be in a not sure category for a while. there come a point of palliation, is information management
enabling approach to indep. enabling vs caring. rehab potential is realised and given the opportunity to improve.
acute hosp not the best place to make decisions sometimes. its about managing risk - what could happen? but
keeping active is important

* need to be resident focused. exercise and activity built into daily routine, need to support resident choice

* use of positive risk assessments. eg low beds to support managing risk of rolling out of bed and risk of injury,
however we are now stopping indep toileting. need to balance those risks, weigh up pros and cons and document
control measures.

* positive risk assessment - is this language common place? language of Positive risk assessment is really helpful, it
supports independence

* positive risk assessment is a good term but it needs some explanation. used in MH setting in management of
behaviour in MH setting

* dont go back to putting people in boxes. need to look at the causes of the fall, risk assessment reminds me of what
we should come away from. we havent come up with someone else. tried to move away from scores, a new tool doesn't
support decision making CCG wanted us to go back.

* difference between risk assessment and falls assessment. these do differ, more person centred - help determine
what measure we need to put in place. MUST braden, waterlow, there's not continuity in falls risk assessment. we all
know the MUST its generic. there needs to be something similar with falls. as care providers we are left to own
devices

* something generic would help. but there would be guidance as its more subjective than skin or nutrition as it relies
on individual circumstances of the fall.

* multi factorial risk assessment, but content varies.
multifactorial risk assessment different skills needed along the continuum.

risk assessment about a moment in time. falls assessment more in depth, professional / medical assessment. eg on DST check list would this help differentiate

* locally depends on the car home. content is indicative of level of training of those who have completed it. does the care home have specialism within care home and know when to pull others in to support

What specialist skills and training is needed to complete a falls assessment for a care home resident?

need specialist skills and training. understand what the risk factors are, both general risk factors and specifics for the home an individual residents.

a tool for grading, low medium and high categories, dont work

a good assessment tool is key, if the tool isn't good it doesn't matter who fills it in. needs to cover every eventuality

clarify the difference between a falls risk assessment and a falls assessment.

needed. specialist set of eyes to keep people up to date with new equipment. need a specialist clinic to support care homes. need one central person in an area, need to know if there anything extra

good knowledge base of the resident is needed. personalised care, if you know what their normal is, you can support a gut feeling if something isnt right. need context for what you want training for. consider hagiarchy in the home, do we need a unified approach or different approaches for different people in the home
interesting that specialist is there, what do we mean by that? would expect people to understand components of a falls assessment. different levels of knowledge, whos the decision makers, who is interpreting those findings. need analysis skills. this can be on a whole home or individual basis.

app to help with those decisions. need to interpret the info not just gather the info

utilise whats already there. if the skills are they lets use them. someon in the home who has experience pull them in for that assessment, ask gp advice when they are there on their round

assessment is not Ix or Rx- theres a difference. assessment care home and staff as well as residents. relationship centred care - family members and the staff looking after them need to be considered.

care home staff know environment far better than visiting professionals. enhanced care in care home approach, CGAs are proactive rather than reactive. different levels of assessment depending on the goal. care home should not be indicative of care recieved.

* difference between a risk assessment and falls assessment. KPI in enhanced health in care home is to ensure all residents have a falls assessment - reality is this is a risk assessment can use d/c summary to support this. its a continuum. a PT will review holistically but also review the risks

**How can technology help in managing falls for care home residents?**

theres a place for tech. call bells, ramble guards and sensors, reduce risk to a degree. can be a culture where people can become reliant and not think of other things which can be beneficial

previous work place we didnt use tech. we used staffing levels
sensor matts and chair matts support knowing if someone is on the move, but this doesn't always work

has a role to play but it should be relied upon, and not take the place of member of staff. eg a home that brought in a system and meant that staff where monitoring it

use chair mats and crash mats low beds, sensors in the bathroom for lights. all to assist carers to be alert. sometimes used wrongly and need to be careful. i would like to see programme where you put in a residents abilities, care and I and factors that affect gait - and that generates ideas on what to looks at. eg medications - do they need to be on this? put in TUAG and timed walking, and it would generate ideas on exercises. support generation of care plans

1:1 or more closely supervised. 1:1 allows greater analysis of falls eg turning too quickly. it can give ideas to support management, eg BP monitoring. 1:1 doesn't reduce risk of falls and doesn't always play a part. monitoring can help - eg if resident is getting up, eg needs the loo or cup of tea. in reality people falls because we cant supervise

aware of assistive tech, and telehealth, to support 'extra eyes' this can be supportive is some circumstances. works for a select number of people, but doesnt stop a fall, just a prompt for need to support or monitoring

lots of equipment, cant replace people. there to support. automatic call bells, need a response and engagement, they act as a prompt. Remote support - video conferencing for expert advice, rather than waiting for a visit. falls monitors to support recording and analysis for the falls events. electron falls mapping to help

appropriate technology needed. falls may have been related to cardiac issue- now fixed, and tech wont help

during lock down completed zoom assessments - staff have adapted. virtual MDTs. get advice virtually. When staff using bleep can un do work with someone tone, eg telephone noise this affects staff as well as residents. voice activated lights. voice activated note writing support documentation. tech should make our lives easier

des have a place with risk assessment and individualised approach. not to be used to cut staffing. easy to tune out call bells if over used
**appropriate, does not replace a person or current interventions. when used inappropriately can increase risk. need to be additional.**

* access to tech - who funds?
* consider if integrated into alarm system, can this be adapted?

**How can individualised falls assessments and action plans be continually reviewed?**

tools for grading are not beneficial

monthly falls audit shows falls previous month but this only shows after the event.

individual falls trackers can support trends and getting a referral through quicker. this isnt always seen as an urgent request which could help those of us who work in homes

on a monthly basis, and or post fall and or post hospital. complete this via audit

we continually review falls. i look at those who falls alot and refer them to falls clinics and GP have physio come in alot. some is realistic, some is not. need a system - eg 10 falls need a GP 15 falls need a clinic, or 2 falls. care plan becoming electronic and automated. similar to waterlow

agree with others. monthly falls audit, support individuals and home as a whole. can delegate roles to key workers to help spready the load. this help up skills and shared responsibility. thinking outside the box, what other elements could support the review, eg QoL elements from the residents, feedback from family, they know the residents. this could highlight issues earlier
there has to be stat review, eg annual review on birthday. know who you recurrent fallers are, or admission due to falls. or either EMAS or urgent care call out. does the resident or home require more support, and how do we flag or review these patients?

do you do this after every falls, after every 5/10. individualised approach. may have someone who is regularly falling, but on to their bottom, not hurt, is this a learnt behaviour. look at the resident and take everything into account

- tech to support identifying patterns.

if under therapy or other active professional input they will have regular review otherwise review monthly. needed post fall. Need to think wider - care home performance in order to support other learning

*** monthly, post fall, on admission

** continued review - monitoring locally incudes " anything changes" can include hospital admission etc

What role does supervision of residents play in the management of falls?

supervision is needed for some residents, to support early intervention. others with 1:1 support will still fall - only need to turn your back for 1 second. need to think about restrictive practice - 1:1 can have detrimental effects

yes, in communal areas especially, staff presence support visual check - can get help in the event of a fall much more quickly

needs to take into account staffing levels, throw away statements of 'needs supervision at all times' its also about the time of day etc. and individual need 1:1 funding and even then its not fail safe
positive and negative elements. +ve good awareness of falls circumstances if a fall occurs, might provide confidence, provide assistance and constant risk assessment. _ve can limit confidence, be overwhelming and generate fear due to being watched.

is it supervision or is it engagement? are we watching or are we engaging to react and enable us to be responsive to someone needs, link with qu. supervising feels restrictive, engaging feels more positive

balance or supervision or anxiety of staff and it become restraint. which leads to frustration and an increased risk of falls. dont want to go back in time, with residents in bath chairs who cant get out. need to work with residents, and promote choice.

sometimes it does and sometimes it doesn't. think about induvial and how easy management could be. cant broadly say 1:1 reduced falls. need to support family and their concerns and anxieties.

supervision has role. requests for 1:1 are high at the moment, need to consider if staff are expecting people to catch a resident. 1:1 can cause more damage. supervision can help if the environment allows it. ned to work within the risk assessment - what the goal?

*** 1:1 does not prevent a fall. can increase risk. needs to be appropriate. its how the 1:1 is implemented

* life after sensors. 1:1 to sensors. harder to come down the risk assessment