



***Foundation Education Resource
For Health and Social Care Workers***

Core Learning - Session Five

Residential Care Setting

Aim:



To provide staff in the Residential Setting with the information and knowledge on the screening assessment and management process for falls and bone health

Residential Setting

- Older People in residential setting are generally frailer than older people living in the community. They are usually older, have more chronic conditions, and have more difficulty walking. They also tend to have thought or memory problems, to have difficulty with activities of daily living, and need help getting around or taking care of themselves.
- Approximately 6% of people aged 65 years and older in Ireland are receiving residential care (CSO, 2012). Of those requiring long-term care, approximately 70% are aged 80 years and older (Department of Health, 2010).

Residential Setting

- Older people in residential settings residents are at highest risk of falls, fractures and osteoporosis. Their rate of hip fracture is 3-11 times greater than age-matched community dwelling older people (HSE, 2008).
- An estimated 50% of older people in residential settings fall each year, this fall rate is more than double the rate for older people living in the community (CDC, 2008).

All Resident Settings Should Have

- A falls prevention and management policy. (Sample Policy Residential setting) <http://hsenet.hse.ie/Hospital Staff Hub/StMary%27sHospitalPhoenixPark/Falls Prevntion Policy.pdf>
- A process for screening assessment and interventions for patients at risk.
- A process for reporting falls and fall related injuries.
- A structure for educating staff on falls and fracture prevention. All staff have a role in preventing falls

Screening and Assessment

Screening: The Aim of screening for falls in older people is to identify those who are at risk of falls(**Appendix2**)

Older persons in contact with Health Care Professionals or their care givers should be asked the following at least once a year:

- Have you fallen during the past years?
- If the older person has fallen, ask about the frequency and characteristics of their falls.
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on Healthy Aging Tips on Bone health
- If the person has had a Single Explained Fall, carry out Gait and Balance Test Get up and Go
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment

Screening and Assessment

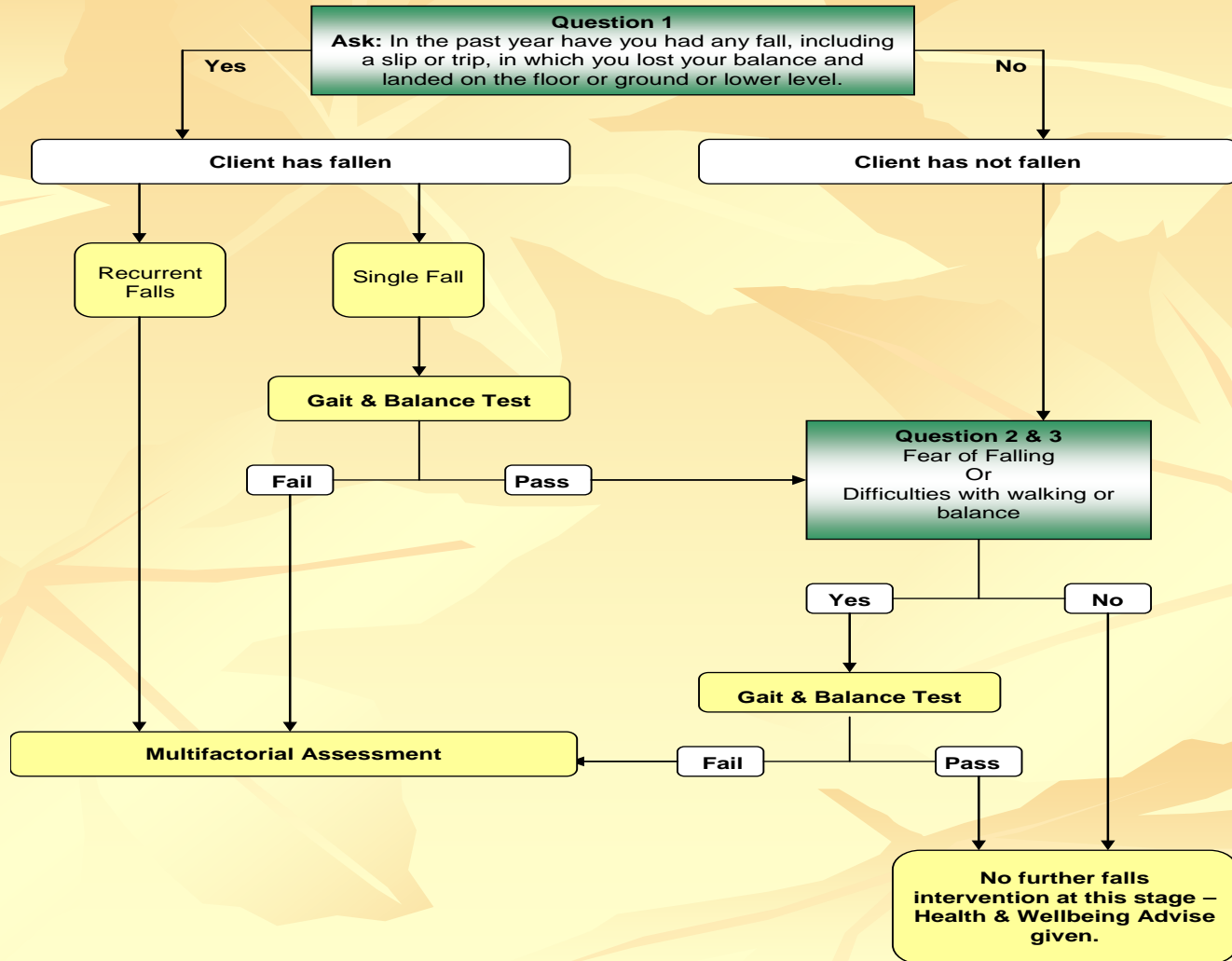
- **Assessment: The Aim** of the multi factorial assessment is to identify the falls risks. A multi factorial fall risk assessment should be performed for older people who(**Appendix3**)
- Report recurrent (2 or more) falls in the past year.
- Report difficulties with gait and balance.
- Report fear of falling.
- Seek medical attention because of a fall.

The multi factorial risk assessment should be carried out and should incorporate the following (Appendix 3)

- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.
- Medications Environmental Issues Feet and Footwear Vision Impairment
Related Medical History Social Factors
- Dietary intake including hydration

Any team member can complete the Multi factorial Fall Risk assessment.

Screening and Assessment



Interventions

- Medication review and withdrawal of psychotropic and other culprit medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.
- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and calcium insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (Adapted from National Strategy HSE 2008)

Interventions (Appendix 8)

Forever Autumn Alerts / Programme

On admission all residents who have any degree of mobility are assessed for their falls risk and an appropriate coloured leaf (green, amber or red) is displayed to indicate their risk as follows:



The green leaf signifies the resident has a low risk of having a fall. Minimum Falls Prevention Standards will be put in place. A leaf **will not** be on display but will be placed next to the residents name on the white board in the Clinical Nurse Manager's Office



The amber leaf signifies a medium risk of the resident having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a yellow 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf **will be** placed next to the residents name on the white board in the Clinical Nurse Manager's Office



The red leaf signifies the resident has a high risk of having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a red 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf **will be** placed next to the residents name on the white board in the Clinical Nurse Manager's Office

Post Fall Care

If a fall occurs while a resident is in residential care, the nurse on duty will inform the Nurse in Charge on the shift

- Check the environment is safe for all
- Take necessary action; scan body for injuries, assess for pain, tenderness, swelling, laceration, irregularities, and deformities and assess if it is suitable to move the person
- Pathway for residents who have had a slip, trip or fall observed / unobserved should be followed (**Appendix 12**)
- Do not attempt to move the resident until sufficient help is available
- Do not manually lift the resident from the floor unless in an emergency situation, e.g., fire, explosion. In the event of cardiac arrest, residents can be resuscitated on the floor (if this is the starting position)

Post Fall Care (contd.)

- If the resident is uninjured and has recovered sufficiently, S/He may be able to get up themselves by rolling onto all fours or into a kneeling position and pulling themselves in a sitting position with the aid of a chair or stool
- If the resident is unable to get up themselves from the floor, then a mechanical aid must be used, e.g., hoist. If the resident is in a confined space a sliding device can be used to move them to a more comfortable area
- Contact the Doctor as soon as possible. Record the name of the Doctor and time, advice received from Doctor in nursing progress notes. Assessment prior to contacting Doctor (**Appendix 14**)

Once the resident is stabilised following any slip, trip or fall, reflect and analyse to prevent a further occurrence, using the Falls Huddle method

Post Fall Huddle Tool

Why do YOU think the resident fell (based on your nursing assessment of the following):

Who fell? When did they fall? Where did they fall? What were they doing when they fell?

Was Assessment undertaken on admission? Is risk status - low, moderate, high?

- Environmental Assessment
- Bedrails up?
- Bed/Chair alarm on?
- Bed in low position?
- Call light within reach?
- Fall history, fall circumstances, and fall risk factors assessment
- Health history and functional status
- Medications and alcohol consumption review
- Vital signs & Pain assessment
- Vision Screening
- Gait, Balance, or Musculoskeletal/Foot
- Continence Assessment

Post Fall Huddle Tool

- Neurological Assessment
- Cardiovascular Assessment
- Depression Screening
- Walking Aids, Assistive Technologies, & Protective Devices Assessment
- Why does your patient think s/he fell ?

Post Fall Huddle Tool

OR - Additional comments

- • What specifically can you change to prevent the resident from falling again?
- • File Fall Incident Report and include any “huddle” insight.
- BE SURE to document patient fall and complete incident form including the following details:
 - • Signs or Symptoms
 - • Previous Fall
 - • Location of fall
 - • Time of Day
 - • Activity at time of fall
 - • Trauma both physical and psychological
 - • Environmental Factors i.e. no handrails, trailing leads etc
 - • Residents factors i.e. no footwear, stocking feet etc
 - • Harm / No Harm

A Resident you Observe Falling

- This is a hazardous situation. The key objective of the handler is to guide the resident onto the floor.
 - If the resident is at a distance from you, do not reach out and try and grab the resident.
 - If the resident is beside you when they begin to fall then release your grip on the resident. Stand slightly behind the client and to the side with your feet in a wide base and allow the client to slide to the floor.
 - Remember to bend your knees while lowering the resident. If possible support the residents head. *Do not attempt to support the full weight of the resident (The Guide to Handling of People 2011).*
 - Should a resident require transfer to the acute hospital or another Health Care facility, the resident Safety Alert form should accompany them.
 - A Clinical Incident Form should be completed.

Safety Precautions for High Risk patients

- Ensure Resident has a call bell to hand
- Check that the Resident knows how and when to operate the call bell
- Explain to the Resident the importance of looking for assistance when needed
- Discuss the Residents walking ability with them
- Ensure that the Residents walking aid (if used) is within reach
- Assess that the Residents environment is free from any potential hazards
- Do not leave Residents with cognitive impairment unattended on commodes, toilets, in baths or showers
- Ensure personal belongings are within easy reach for the Resident

(Adapted from NHS Scotland, 2011)

Residential Setting - Resources

Resources

- Falls Prevention and Management Policy St Mary's Hospital Phoenix Park
http://hsenet.hse.ie/Hospital_Staff_Hub/StMary%27sHospitalPhoenixPark/Falls_Prevention_Policy.pdf
- Multi Factorial Assessment and Intervention – Appendix 8
- Gait and Balance Test (Get Up and Go) – Appendix 7
- Osteoporosis Poster – www.bonehealth.co
- Fall Safe Care bundle www.bgs.org.uk/campaigns/fallsafe
- Safety Alert Form – Appendix 11
- Intentional Rounding Chart –Appendix 10
- Pathway for Care of service user Post Fall – Appendix 12
- Assessment Prior to Contacting Doctor – Appendix 14
- Northern Ireland Nursing Home Regional Collaborative, Falls Prevention Toolkit – www.publichealth.hscni.net
- Bone health in the Park Forever Autumn (2011/12) www.bonehealth.co

List of Appendices with Sample Tools

- [Appendix 1: I had a fall poster](#)
- [Appendix 2: Level 1 Screen](#)
- [Appendix 3: Level 2: Multi-factorial Falls Risk Assessment](#)
- [Appendix 4: Falls Safety Cross](#)
- [Appendix 5: Quick Tips for Healthy Bones](#)
- [Appendix 6: Tips for Healthy Ageing](#)
- [Appendix 7: Get Up and Go Test](#)
- [Appendix 8: Multi factorial Assessment and Intervention](#)
- [Appendix 9: Sample Policy Acute setting](#)
- [Appendix 10: Intentional Rounding Chart](#)
- [Appendix 11: Safety Alert Form](#)
- [Appendix 12: Pathway for care of older person Post Fall](#)
- [Appendix 13: Post Falls assessment management pathway](#)
- [Appendix 14: Nursing Assessment prior to ringing the G.P](#)