Download the free React to Falls app

App Store

Google Play

Or, access the website via: https://www.reactto.co.uk/resources/react-to-falls/

ACTION FALLS

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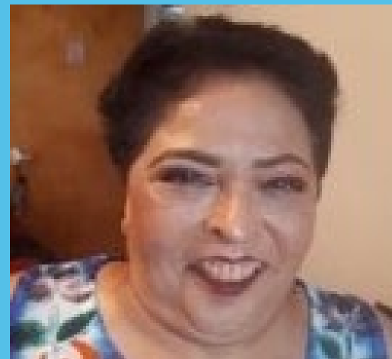
FALLS IN CARE HOME RESEARCH AND THE ACTION FALLS PROGRAMME

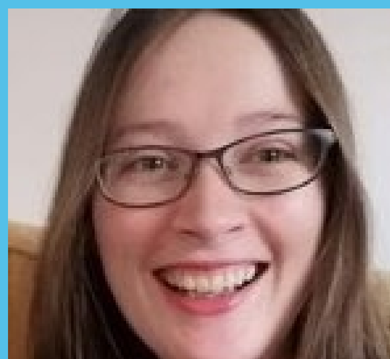
PROF PIP LOGAN

OVERVIEW

- Brief overview of the Falls in Care Homes Research
- Outline of the ACTiON FALLS programme
- How it works and what is involved
- Further work we are doing
- Resources you can access

RESEARCH TEAM





Why care homes?

- **421,000** older people living care homes, 15,000 homes
- Falls are at least **three times** more frequent in care homes than in a community dwelling older person
- Can lead to injuries, loss of independence and fear of more falls
- **Anxiety** in care home staff around falls
- **60-80%** of residents are cognitively impaired

Falls in Care homes – Clinical Trial

A programme of activity designed to prevent, manage or reduce falls...

Because falls cause injuries and distress

Because falls are three times more likely to happen in a care home than in people living in their own home

The Guide to Action Care Homes (GtACH) programme was designed by researchers, care home staff and residents to prevent falls in care homes. It includes training, resources, case studies and list of actions.

That was tested in the biggest care home study in the UK (10 sites)

That **84** care homes took part in

Received normal care

Received normal plus the GtACH programme

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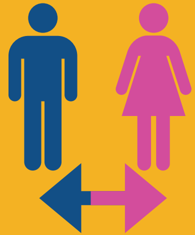
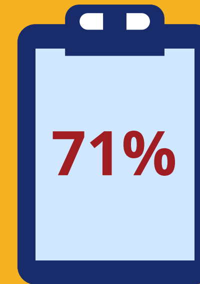
Falls in Care homes – Clinical Trial

1657 CARE HOME RESIDENTS TOOK PART IN THIS STUDY...

With a mean age of 85 years old



68% were Female and 32% were Male



GtACH training was delivered to 71% (n=1051) of staff in over 146 training session

88 participants took part in the Process Evaluation through...

interviews **44**

focus groups **11**

This included management, care staff, residents and the fall leads.

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Falls in Care homes – Clinical Trial

The GtACH Programme:

Reduced falls by 43%

Was cost effective

Costing £108 per resident

Did not affect residents' activity and dependence levels

Offers benefit in the management of falls, however, in practice care homes operate differently.

Our next study, FinCH Imp, aims to find how best to use GtACH programme in everyday practice.

Thank you for your participation in this study. Success!

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What is the intervention?
Where are we now?

Action Falls Programme (formally GtACH)

Guides their (care staff) thought processes CH1

Facilitates 'thinking outside the box' CH2

Falls in Care homes implementation study (FinCH Imp)

Falls are common, harmful, costly and difficult to prevent[1]

The Action Falls Programme (formally GtACH) uses resources, skill sharing and training to support care home staff to identify the reasons why their residents might fall. It prompts and guides staff to complete actions to reduce falls.

Recent Trial showed a 43% reduction in Falls[1]

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Falls in Care homes implementation study (FinCH Imp)

Action Falls Checklist (resource)

1 hour care home training programme

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What We Know from Our Research

The FinCH training delivered to the care home staff was viewed positively

Training generated a shared understanding that all staff have a responsibility for managing falls

Staff need to be encouraged to use the Action Falls Checklist to cement their knowledge and reduce the risk of learning diminishing over time

The care homes liked the multiple training sessions as they fitted around shift patterns

Training increased staff knowledge and awareness of falls risks and provided the confidence to take actions prevent falls

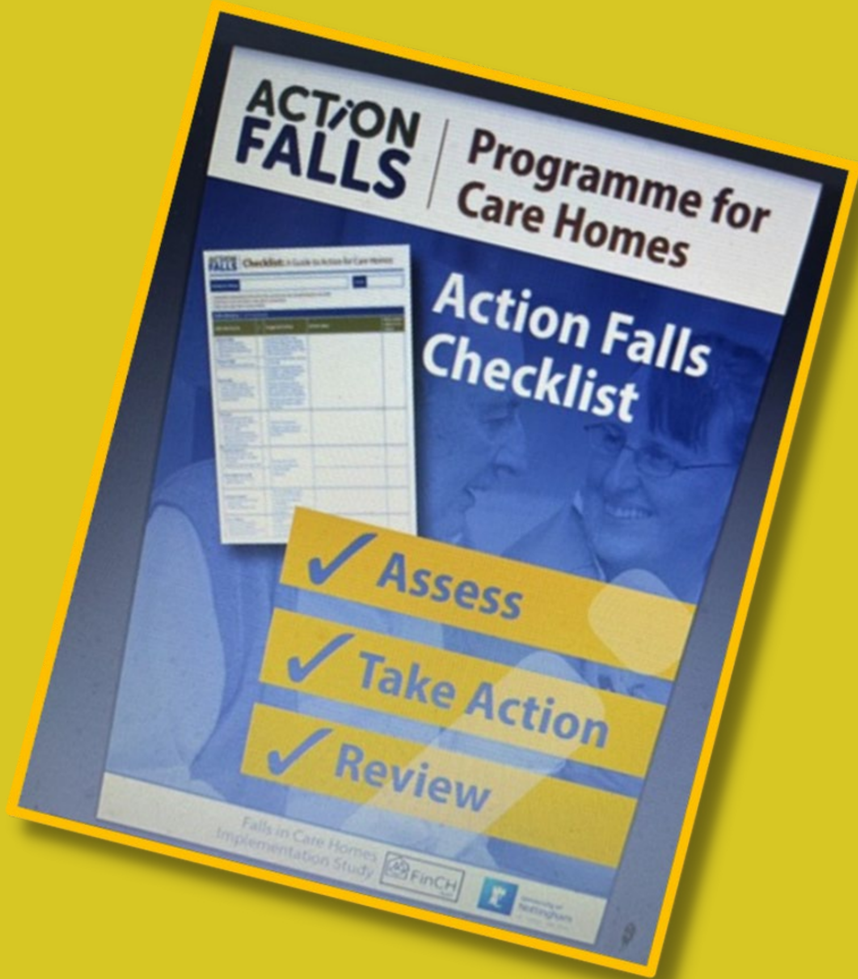
The Action Falls Manual for Care Homes

Falls Analysis Log

Traffic light medication chart

Action Falls Checklist (paper)

Falls Awareness Poster



Falls Lead
(NHS)

Falls Champion
(Care Home)

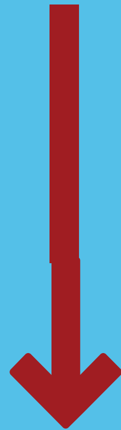
What is the Action Falls Checklist?

- The Action Falls Checklist has been devised in previous research studies with care home staff
- It is a list of risk factors known to increase the risk of falls
- It has a list of suggestions for actions that could be taken to reverse or modify the risk factors
- The Action Falls Checklist is an individualised assessment for that person with individualised actions relevant to their situation

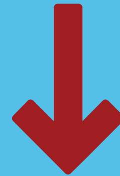
Action Falls

Falls risk factors		Suggested action	Action taken	Date action taken & by whom

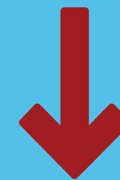
Circle or underline risk factors that are relevant to that person



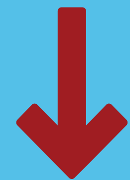
Tick the box if a risk factor was identified



Circle or underline actions you will take



Document what actions you have taken. If the person or family do not consent to action, document here. Also document steps already taken to reduce risk prior to the checklist being introduced



Sign and date when the action has been taken

Resources

- Access to the ACTiON FALLS resources
- Free access to React to Falls website and APP
- Results in the research demonstrated through the formal training (this presentation doesn't cover this) from NHS falls lead and on-going support

http://www.reactto.co.uk/resources/react-to-falls

ACTiON FALLS

Mobile Application & online resources

Let's try it...

Falls in Care homes implementation study (FinCH Imp)

60 Care Homes

Publications

Thinking falls – taking action: a falls prevention tool for care homes. Robertson K,Logan P, Ward M, Pollard J, Gordon A, Williams W, Watson J. (2012). British Journal of Community Nursing, 17(5), 206-209.

Thinking falls - taking action: a guide to action for falls prevent Robertson K,Logan P, Conroy S, Dods V, Gordon A, Challands L, Smith S, Humpage S, Burn A. (2010). ion. British Journal of Community Nursing, 15(8), 406-410.

Evaluation of the Guide to Action Care Home fall prevention programme in care homes for older people: protocol for a multi-centre, single blinded, cluster randomised controlled trial (FinCH). Logan PA, McCartney K , Armstrong S , Clarke A , Conroy S , Darby J , Gladman J, Godfrey M, Gordon AL, Irvine L, Leighton P , Mountain G, Robertson K , Robinson K, Sach T , Sims E, Horne JC. East Midlands Research into Ageing Network (EMRAN) Discussion Paper Series ISSN 2059-3341 Issue 25, February 2019

The Falls In Care Home study: A feasibility randomized controlled trial of the use of a risk assessment and decision support tool to prevent falls in care homes Walker GM, Armstrong S, Gordon AL, Gladman J, Robertson K, Ward M, Conroy S, Arnold G, Darby J, Frowd N, Williams W, Knowles S and Logan PA, 2015. Clinical Rehabilitation. 30(10), 972-983

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Developing the React to Falls resources to support care home staff in managing falls. Robinson KR, Jones K, Balmbra J, Robertson K, Horne J, Logan PA. J Frailty Sarcopenia Falls. 2019 Mar 1;4(1):1-10. doi: 10.22540/JFSF-04-001. PMID: 32300710; PMCID: PMC7155373.

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CARE OF THE OLDER PERSON

Thinking falls – taking action: a falls prevention tool for care homes

Kate Robertson, Pip Logan, Marie Ward, Julia Pollard, Adam Gordon, Wynne Williams, Julie Watson

Kate Robertson is Falls Clinical Specialist, County Health Partnerships, Nottingham; Dr Pip Logan is Clinical Associate Professor in Community Rehabilitation, University of Nottingham; Marie Ward is Falls and Bone Health Clinical Specialist, Nottingham CityCare; Julia Pollard is formerly Team Leader, Nottingham CityCare; Dr Adam Gordon is a consultant in geriatric medicine, Nottingham University Hospitals NHS Trust; Wynne Williams is Manager, Church Farm Nursing Home, Nottingham; Julie Watson is Deputy Manager, Church Farm Nursing Home, Nottingham

Email: kate.robertson@nottshc-chp.nhs.uk

Falls in older adults are common. There is considerable mortality and morbidity associated with falls in care homes, with hip fracture rates significantly higher than in community-dwelling older people, and rates in female care home residents being estimated as high as 50.8 hip fractures per 1000 person years (Rapp et al, 2008). Due to the seriousness of this injury, one fifth of those people will die within a year (Cooper et al, 1993; Liebson et al, 2002). In frailer older people with three or more comorbidities, mortality rises to 33% within a year of fracture (Roche et al, 2005). Beaupre et al (2007) found that most people admitted to hospital from long-term care facilities following a fall and fractured hip do not regain their pre-fracture level of function.

Although extensive research has been carried out into effective interventions to reduce falls in community-dwelling older people, there is limited evidence of the effectiveness of such interventions within care homes. In a meta-analysis of falls interventions in a care home setting, Oliver et al (2007) concluded that there was insufficient evidence regarding falls prevention in this setting and that further research is required, but suggested that it makes sense to identify risk factors for the individual and reverse or reduce these where possible. This was supported by Close and Lord (2011) in their clinical review of falls risk-screening tools. A further issue is that protocols used to perform risk assessments for falls are often not validated, vary from care home to care home, and do not necessarily trigger individually-tailored interventions (Oliver et al, 2000).

We have previously reported the development of a Guide to Action for Falls Prevention Tool (GtA) for use with community-dwelling older people (Robertson et al, 2010). In this article we outline our development of a version for use within care homes: the Guide to Action for Falls Prevention Tool – Care Homes (GtACH).

Method

Development of the GtACH

The GtACH was developed using published meta-analyses and randomised controlled trials, where studies identified risk factors for falling significant to older people within care homes (not just UK studies) and effective interventions shown to reduce falls and injuries in this setting.

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ACKNOWLEDMENT

Participants, families and friends
Care Home Staff and Owners

Jane C Horne, Frances Allen, Sarah J Armstrong, Allan B Clark, Simon Conroy, Janet Darby, Chris Fox , John RF Gladman, Maureen Godfrey , Adam L Gordon , Lisa Irvine , Paul Leighton, Karen McCartney , Gail Mountain, Kate Robertson , Katie Robinson, Tracey H Sach, Susan Stirling, Edward CF Wilson, Wynne Williams and Erika J Sims

The Trial Steering Committee, Data monitoring Committee, Clinical Research network, ENRICH, NHS Falls Services, University of Nottingham, Birmingham, Northumbria Students

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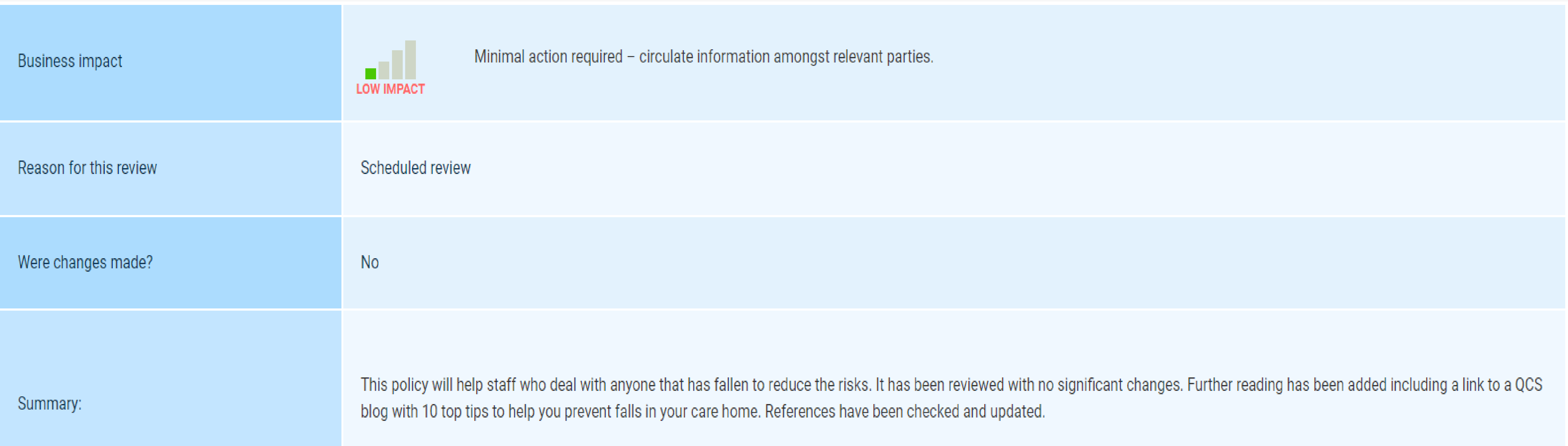
THANK YOU!

CC35 - Falls Management Policy and Procedure

Review Sheet

Last Reviewed	Last Amended	Next Planned Review
21 Oct '22	21 Oct '22	12 months, or sooner as required.



Business impact	LOW IMPACT – Minimal action required – circulate information amongst relevant parties.
Reason for this review	Scheduled review
Were changes made?	No
Summary:	This policy will help staff who deal with anyone that has fallen to reduce the risks. It has been reviewed with no significant changes. Further reading has been added including a link to a QCS blog with 10 top tips to help you prevent falls in your care home. References have been checked and updated.

11. Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Falls Risk Assessment - CC35	For all Service Users who have been identified as at risk.	QCS
Post Falls Procedure - CC35	When a Service User has had a fall	QCS
Falls - Incident Log - CC35	Following any fall, found on floor or near miss.	QCS
24 Hour Post-Fall Observation Log - CC35	As soon as possible following a fall	QCS

CS224 - Falls Risk Management Care Plan - Example

Service User Name	*Mrs Jane Smith*	**Room Number**	*10*

Abilities, preferences, goals:
∘ *State if Mrs Smith has a history of falls and how this has been managed to date* ∘ *What techniques work to reduce anxiety around falling again* ∘ *What aids are used, if any* ∘ *State if Mrs Smith is under the care of a physiotherapist/falls related professional*

What does a good day look like?	What does a not so good day look like?
Weight bearing and movement is good, and Mrs Smith can walk from the lounge to the bedroom.	*Mrs Smith can find it difficult to stand from her chair and may need prompting and time to do this, but once up can mobilise well.*

Support needed from staff:
∘ *Cross reference to the **Falls Risk Assessment** to determine the risk and **frequency of review**. How the situation may reduce the risk, e.g. nursed in bed but high risk* ∘ ***Document all falls, near misses or unwitnessed events**. Staff should recognise, report and record any changes in condition. Use a **falls diary** to log and track themes* ∘ ***Medication or alcohol** - how staff can support with managing and reducing risk due to this* ∘ *Medical conditions - stroke, Parkinson's - cross reference to a separate Care Plan, are they under the care of a health care professional/falls service?* ∘ ***Sensory impairment** - such as vision problems, how staff support them. Instability, balance and physical activity - how staff will promote exercise and activity*

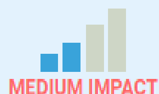
HS01 - Accident and Incident Reporting Policy and Procedure

Review Sheet

Last Reviewed 13 Jun '22

Last Amended 13 Jun '22

Next Planned Review 12 months, or sooner as required.

Business impact	 MEDIUM IMPACT Changes are important, but urgent implementation is not required, incorporate into your existing workflow.
Reason for this review	Improve usability
Were changes made?	Yes
Summary:	This policy will support a service to ensure accidents and incidents are recorded and reported correctly. It has been reviewed with wording clarified in section 5.5 to reference that incidents may need to be reported to the CQC. A weblink has been added to the full list of incidents detailed in the text of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 in the Underpinning Knowledge/References section. Reference to the Serious Incident Notification Policy and Procedure and the Duty of Candour Policy and Procedure has been added in Further Reading. All other references have been checked and updated.

Accident and Incident Log – Service User

Name:		Date of birth:
Time and date of accident/incident:		
Precise location of accident/incident:		
How did the accident/incident happen (initial report)?		
Name of witness(es):		
Details of apparent injuries or harm (refer to policy definitions for clarification):		
What immediate and monitoring action was taken to ensure that the Service User was appropriately supported, and their health was effectively managed?		
Reasons given for cause of accident/incident by Service User:		
Reasons given for cause of accident/incident by witness(es):		
Report causes and recommended action by investigator:		

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CityCare

10 top tips to help you prevent falls in your care home

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