NHS
South Western
Ambulance Service
NHS Foundation Trust

Post Falls Guidance Pack for Care Providers

Contents

1. Introduction

1.1. Even when all possible steps have been taken to prevent them, a certain number of falls are inevitable. A fall is defined as “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level” (WHO, 2021). This guidance has been developed to support care providers across the South West to assist service users when a fall happens and to encourage the appropriate use of emergency services in these circumstances.

1.2. This guidance pack can be used as a training tool and reference document for any care provider seeking clarification on best practice. It does not replace any pre-existing policies or guidance where these are working well. Although this guidance provides a good basis for the majority of situations carers may encounter, it cannot foresee every possibility and must always be used in combination with clinical judgement, where applicable, common sense and in line with duty of care.

1.3. This guidance has been developed as part of collaboration with domiciliary care agencies and care/nursing homes across the South West. This is based on a variety of sources including reports from the National Patient Safety Agency and the National Institute for Health and Care Excellence. Much of the evidence base comes from the inpatient environment but has been adapted here for nursing and care homes and care agencies.

2. No Lift and Minimal Lift Policies

2.1. Those who work as health and care providers should not be expected to physically lift service users who have fallen using only bodily force. In the case of a non-injury fall it may be possible to facilitate a service user to self mobilise using verbal cues (see useful resources), but where this is not possible the use of appropriate manual handling techniques, other manual handling aids or mechanical lifting equipment with support from additional members of staff may be required.

2.2. In the case of a non-injury fall care providers should exhaust all possible options in the first instance before calling 999. This includes liaison with the on-call manager for the organisation.

2.3. When dialing 999, a call taker or clinician may request that the care provider lift a service user, and the expectation would be for the carer to facilitate the service user off the floor as detailed above in 2.1.

2.4. South Western Ambulance Service NHS Foundation Trust is not commissioned to provide a lifting service for patients who are uninjured. There is an expectation that under the statutory requirements of care providers (2.4 and 2.5), appropriate manual handling techniques and or equipment will be used to assist service users who have fallen and an ambulance will only be requested when there is an apparent or major injury/illness to the service user (please refer to the decision making tool in section 3).

2.5. Under the Health and Social Care act 2008, it is understood that there are inherent risks in carrying out care and treatment and a post fall response will not be considered unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of the person using their services, and to manage risks that may arise during care and treatment.

3. Post Falls Guidance

3.1. Post Fall Decision Making Tool

3.2 To support structured handovers with Health Care Professionals including the ambulance crew, an SBARD tool is available at https://www.swast.nhs.uk/welcome/care-providers/patient-handover.

3.3 When a decision has been made that an ambulance will convey the service user, an *Ambulance Admission* form (Appendix 2) must be completed and handed to the ambulance clinicians upon their departure. Please also ensure that the following items travel with the patient:

- Up-to-date Medication Administration Record (MAR) sheet.
- Clothes, including appropriate footwear if the resident can mobilise.
- Hearing aids and glasses if worn.
- Care Plans, including Treatment Escalation Plans or DNAR forms.

4. Additional Notes for Care Providers

4.1. Unwitnessed Falls: The nurse or carer, with support from senior members of care staff, should use their judgement and knowledge, where applicable, of the service user when discovering an unwitnessed fall. For example, if a fall is discovered on the first visit of the day, there is clearly a risk that the service user has been on the floor all night. Even if the service user appears uninjured, in this situation, additional advice from a GP or NHS 111 should be sought. It is important to mention to whoever is taking the call that the fall was unwitnessed.

4.2. Response Time from GP/ NHS 111: We recognise that there may be a significant delay in getting a response from a service users' GP or the NHS 111 service for advice. We recommend that wherever possible the carer should wait with the service user until they are called back. However, when this is not possible, providers are advised to utilise any other support that may be available in line with provider policies.

4.3. 24 Hour Observation: We recognise that observation for 24 hours post fall may not be possible for care agencies to provide themselves. Providers are advised to utilise any other support that may be available. A plan should be agreed with senior care staff which could include, but not limited to:

- Use of visits later in the day (additional visits could also be requested from care provider Commissioners; although there is no guarantee that these will be approved).
- Use of a 'Responder List', pre agreed with the service user, consisting of family and friends who have agreed to be contacted in case of a fall. Responder may visit the service user or may choose to contact them via telephone to check on wellbeing.
- Use of tele-healthcare, if installed.

4.4. Communication Difficulties: Where the service user is unable to provide a reliable account of the fall or articulate any pain they may be in, the carer (with support from senior members of staff, where available) should, where possible, use their knowledge of the service user and non-verbal signs to judge the most appropriate course of action. Even if the service user appears uninjured additional advice from a GP or NHS 111 may be required. Where such advice is being sought, it is important to mention that the service user is unable to provide a reliable account of the fall. Any advice or suggested interventions given by the GP/NHS 111 should be documented.

4.5. Intermediate Care Referrals: Where a service user is able to stay at home post fall, or declining conveyance but their normal functioning is impacted, an intermediate care (or other appropriate local team) referral may be appropriate in order to provide rehabilitation or additional equipment to reduce further risk.

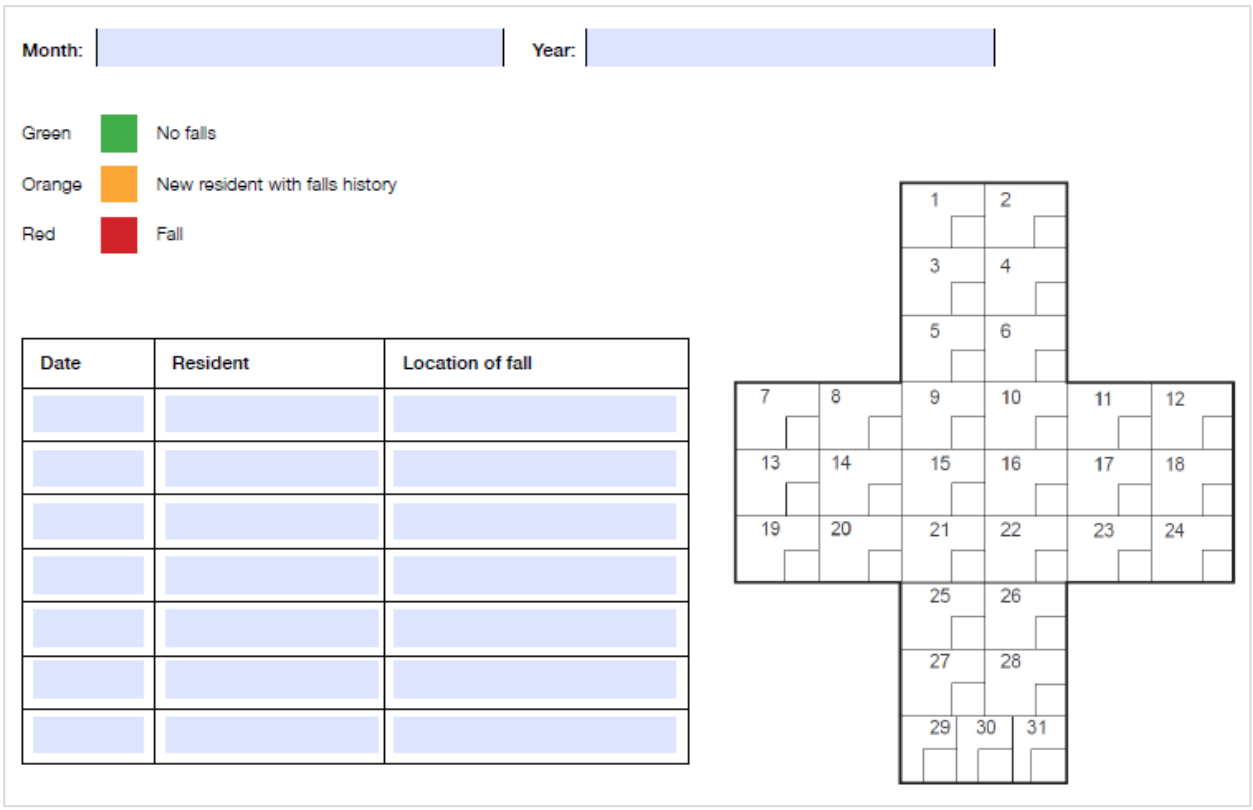
4.6. Documentation: It is important to comprehensively document the fall, the events surrounding the incident and the ongoing care plan in the service users care notes to ensure that any subsequent visiting family, carers or other healthcare professionals are aware of the fall and can help to support the service user safely in their own home. Recording when, where and how a service user has fallen is vital for identifying patterns and regularity of falls and helps to provide an accurate history for future clinical assessments. Near misses should also be documented. See Appendix 1 for example documentation.

5. Documenting Falls and Near Misses

5.1. Service users who fall should have this recorded on the relevant documentation. Critical incident analysis helps to develop awareness and learning culture amongst staff and ensures action is taken to minimise future incidents, especially where there are trends.

5.2. Depending on the care setting, there are a number of suggested ways to log falls or near misses. Image 1 provides an example of a tool to document falls for each day of a month with the aim of using the data to raise awareness within the team regarding how many falls there have been and promote good practice. However, it is important to link the data to an improvement aim rather than it being purely for reporting purposes e.g. reducing the number of falls by 20% over a 6 month period.

5.3. Image 1: Falls Safety Cross- (courtesy of 'The Care Inspectorate')



5.4. Alternatively, for service users who are at risk of regular falls, a falls map should be considered. On a falls map, a footprint of their place of residence is annotated to highlight where an individual has fallen, at what time of day and any other relevant information e.g. during a period of illness, of after an introduction of a new medication. This helps to identify patterns so that appropriate falls prevention interventions can be implemented.

6. Useful Resources

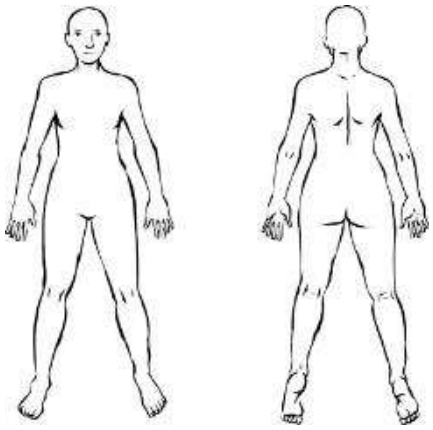
- Post falls documentation: https://www.swast.nhs.uk/assets/1/fallsexampledocumentation.pdf
- What to expect when you call 999: https://www.swast.nhs.uk/welcome/care-providers/what-to-expect-when-you-call-999
- Care providers Frequently Asked Questions: https://www.swast.nhs.uk/assets/1/careprovidersfaqs.pdf
- Post falls video blogs and training checklists: https://www.swast.nhs.uk/p/post-falls-assessment
- The National Institute for Health and Care Excellence has collated a number of Tools and Resources relating to assessing risk and the prevention of falls: https://www.nice.org.uk/guidance/cg161/resources
- The Chartered Society of Physiotherapy, Saga and Public Health England have produced a 'Get Up and Go' leaflet for older people which tackles common myths about falling, how to self-assess falls risk and advice on what to do if you fall (with a pictorial guide on how to get up off the floor). The leaflet can be downloaded here: www.csp.org.uk/publications/get-go-guide-staying-steady

7. References

- Care Quality Commission (2015); Guidance for Providers on Meeting the Regulations
- Devon County Council; Falls Resource Pack: Falls Prevention is my Intention; https://new.devon.gov.uk/providerengagementnetwork/files/2015/06/Falls-Prevention-Resource-Pack-.pdf
- Hampshire County Council Adult Services (2015); Post Falls Protocol; http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/4-Hampshire%20falls%20protocol.pdf
- National Institute for Health and Care Excellence (2013); Assessment and Prevention of Falls in Older People CG161; https://www.nice.org.uk/guidance/cg161/evidence/falls-full-guidance-190033741
- National Institute for Health and Care Excellence (2015); Falls in Older People QS86; https://www.nice.org.uk/guidance/qs86/resources/falls-in-older-people-2098911933637
- National Patient Safety Agency Rapid Response Report NPSA/2011/RRR001 (2011); Essential Care after an inpatient fall and Supporting Information; http://www.nrls.npsa.nhs.uk/alerts/?entryid45=94033
- Torbay and Southern Devon Health and Care NHS Trust (2015); Post Falls Flow Chart for Community Staff Action.
- The Care Inspectorate (2016); Falls Cross http://www.careinspectorate.com/images/documents/2737/2016/Tool_21b_NEW_interactive.pdf
- Who.int. 2021. *Falls*. [online] Available at: https://www.who.int/news-room/fact-sheets/detail/falls [Accessed 6 September 2021].

Appendix 1 – *Example Falls Documentation*

Name of Resident:			
Place of Residence:			
Date of Fall:		**Time of Fall (if known)**	
Staff Name:		**Job Title:**	
Date Completed:		**Time Completed**	

ASSESSMENT			
Level of Consciousness	Conscious and responding as usual ☐	Less responsive than usual ☐	Unresponsive or unconscious ☐
Pain and Discomfort	No pain or discomfort ☐	Slight discomfort ☐	Pain and/or some discomfort ☐
Injury and Wounds	No apparent injury - No bruising or wounds, no signs of limb deformity, shortening or rotation ☐	Minor bruising or skin wounds but no signs of limb deformity, shortening or rotation ☐	Uncontrolled bleeding, limb deformity, swelling or extensive bruising ☐
Movement and Mobility	Mobility unaffected: Able to move limbs as usual on command or spontaneously ☐	Mobility affected: Unable to move limbs as usual or major change in mobility ☐	
Body chart relates to the physical assessment. Indicate location of visible or suspected injury or complaint of pain/discomfort. **B** = Bruise **P** = Pain **W** = Wound **S** = Swelling **F** = Fracture			

Basic Observations (where possible)								
Time	AVPU	Blood Pressure	Respiratory Rate	O^2 Level	Capillary Refill	Blood Glucose	Heart Rate	Temperature

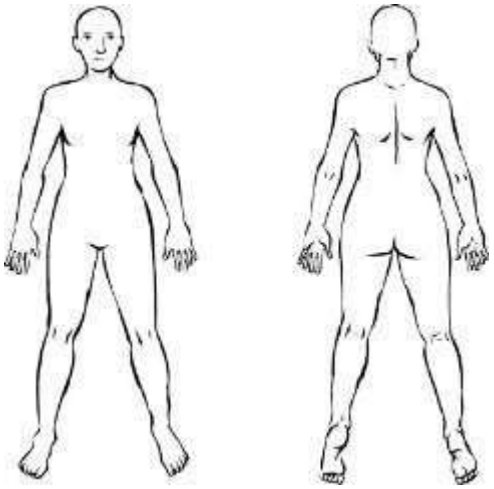
Further Actions

- Inform relatives and/or GP
- Consider installation of Tele HealthCare
- Document and inform all staff of fall.
- Consider referral to Intermediate Care Services or falls team where available

Appendix 2 – *Ambulance Admission Form*

Admission Form

Date of Call:		Time of Call		
Patient Name:		Patient DOB and Age:		
Care Home Name and Address:		Care Home Phone Number:		
		Nurse/Manager in Charge:		
Reason for 999 Call:				
Next of Kin (NOK): *(tick if informed)*	☐	NOK Contact Number:		
GP Name and Surgery:		Surgery Contact Number:		
Has the patient seen a GP in the last 2 weeks? *(circle as appropriate)*	Yes / No	*If yes, please provide the following details:* Date: Reason for consultation:		
Past Medical History:				
Current Medications:				
Known Drug Allergies:				
How does the patient normally mobilise?				
How does the patient normally communicate?				

Details of treatment given by nursing/care home staff prior to ambulance arrival:				
Where possible please note any clinical observations taken prior to ambulance arrival:		**Time:**	**Time:**	**Time:**
	Heart Rate			
	Respiratory Rate			
	Blood Pressure			
	Temperature			
	Oxygen Saturations			
Body chart relates to any physical assessment. Indicate location of visible or suspected injury or complaint of pain or discomfort. Key: B = Bruise P = Pain W= Wound S = Swelling # = Fracture				
Does the patient have a care plan in place? *(circle as appropriate and provide details)* ***NB. An original copy of the document should travel with the patient***	Treatment Escalation Plan(TEP) or ReSPECT	Yes / No		
	Do Not Attempt Resuscitation form (DNAR)	Yes / No		
	Advanced Decision to Refuse Treatment (ADRT)	Yes / No		
	Other (please state):			
Does the patient have a Lasting Power of Attorney (LPoA)? *(circle as appropriate)*	Health and Welfare:	Yes / No	*If yes, please provide the following details:* Name: Relationship to patient: Contact details:	
	Property and Financial affairs:	Yes / No	*If yes, please provide the following details:* Name: Relationship to patient: Contact details:	
Is the patient known to	Clostridium difficile (C-diff)		MRSA	

be infectious? *(place tick next to any that are relevant and provide additional details where required)*	Covid-19		Norovirus		
	Diarrhoea and/or vomiting		Scabies		
	Escherichia coli (E-coli)		Shingles		
	Influenza		Streptococci		
	Measles		Tuberculosis (TB)		
	MERS		Other:		
	Additional details:				
Record of property being conveyed with the patient					
Will anyone be travelling with the patient? *(circle as appropriate)*	Yes / No	*If yes, please provide the following details:* Name: Relationship to patient: Contact details:			
Name of staff member completing form:			Signature		

Appendix 3 – *National FAST campaign- for Assessment of Stroke*