Falls collaborative - learning session 9

SWALEC stadium Cardiff
11th March 2014

Up and About in care homes

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Todays session

- Scottish picture
- Why care homes?
- Introduction to the care home resource pack and tools.
- Snippets from the evaluation.
- Current project – Up and About in care homes.
- Over to you for a while….next steps.
- New resource to promote physical activity in care homes.
Who am I?

- National improvement role.
- Strategic leadership role.
- Based in the Care Inspectorate.
- Focuses on older people.
- External/internal focus.
- Influencing health and social care policy.
- Promoting the care sector and solution focused.
What is the Scottish picture?

- Total population of Scotland (30 June 2012) 5,313,600.
- Care homes for older people (31 December 2013) 899.
- Total registered capacity 38,450 places (868 homes).

Breakdown of services (868 homes)
Private 70%
Local Authority 15%
Voluntary/not for profit 13%
Health Board 2% (Highland)
Grading in care homes for older people  (31 Dec 2013)

- 21% of care homes for older people had grades of 5 or 6 for all Quality themes.
- Only 3% of care homes for older people had all quality themes graded at 1 or 2.

By Quality Theme:

- Quality of Care and Support - 32% of services have a grade 5 or 6, 8% of services have a grade 1 or 2.
- Quality of Environment - 33% of services have a grade 5 or 6, 7% of services have a grade 1 or 2.
- Quality of Staffing - 37% of services have a grade 5 or 6, 4% of services have a grade 1 or 2.
- Quality of Management & Leadership - 31% of services have a grade 5 or 6, 7% of services have a grade 1 or 2.
Challenges – the same everywhere?

• Culture.
• Lack of infrastructure.
• Leadership and mentorship.
• Staff – turnover and capacity.
• Access to resources and training.
• Permission to do things differently.
• Risk benefit analysis.
• Inconsistencies – training, approach.
• Information sharing - across care sectors, health and social care.
• Accessing local wider health and social care services.
• Lack of involvement in local community planning.
• **Lack of recognition that care homes are part of the community – rights and citizenship**

However …..there is an appetite for improvement
Falls matter!

_in people 65 years and over:_

- Largest single presentation to the **Scottish Ambulance Service (over 35,000 attendances)**.
- One of the leading causes of **Emergency Department** attendance.
- Responsible for over **390,000 emergency bed days**.
- Implicated in up to **40% care home admissions**.

Costs to health and social care services in Scotland estimated to exceed **£471m** each year (est. rising to **£666m** by 2020):

- 45% long term care.
- 40% NHS.
- 15% care at home.
**Aim:**
For every health and social care partnership area in Scotland to have a local integrated falls and fragility fracture pathway for older people *in operation* by the end of 2014.
Why focus on care homes?

- Evidence of a big issue*
  - Falls incidence 3 times higher.
  - 10 times more likely to have a hip fracture.
  - Rate of emergency admissions due to falls in people aged over 65 living in Care Homes is almost four times higher. (22 million)

- Policy context
  - Reshaping Care for Older People (change fund opportunities)
  - National Delivery Plan 2012

- National Falls Programme mapping findings.

- Care Inspectorate Inspection Focus Area 2009-2010.

- Leadership – key national posts.

- Support from Scottish Government and Care Inspectorate.

(* Luukinen 1994; Rubenstein 1994; Butler 1996)
Data from notification of falls

(NB: figures should be regarded as estimates as accurate information is dependant on services reporting events accurately and appropriately)

Data was extracted from Notifications on: Incidents, Accidents, Death of Service User, Injury to Service User.

The data was searched for the following terms, to identify those cases involving falls: ‘fall’, ‘fell’, ‘fallen’, ‘trip’, ‘stumble’.

<table>
<thead>
<tr>
<th>Notification type</th>
<th>Number of cases submitted in 2012/13 relating to 'falls'</th>
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<tbody>
<tr>
<td>Accident</td>
<td>1443</td>
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<tr>
<td>Injury to Service User</td>
<td>358</td>
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<tr>
<td>Incident</td>
<td>234</td>
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<tr>
<td>Death of a Service User</td>
<td>160</td>
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<td><strong>Total</strong></td>
<td><strong>2195</strong></td>
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</table>

This volume of cases leads to an average of around 2.4 notifications per Care Home in 2012/13.

(source data: extract of RMS notifications taken on 12th February 2014)
Care home residents being prescribed powerful drugs for long periods of time without proper checks on whether the medication is needed..... This leads to increased falls risk.

A educational and improvement solution required!
The purpose of the resource

• To get all stakeholders thinking, talking and doing something about falls prevention and management and fracture prevention in care homes.

• To articulate what ‘good practice’ means.

• Provide answers to many of the questions care home managers and staff have about falls and fracture prevention/management.

• Provide some practical solutions.

• Provide a catalyst for care homes to develop stronger links with the wider health and social care team.

• To improve the quality of care in this area and maintain people in their home environment.
Developing the resource

- Self-assessment
- Multi-agency Working Group June 2010
- Early implementers Oct 2010 – April 2011
- Advoirs identified July 2010
- Consultation Feb-March 2011
- Feedback from early implementers Feb-April 2011
- Awareness DVD developed April 2011
- Final changes May 2011
- Gather and write July 2010
- Awareness DVD developed April 2011
Sound bites

- It changed practice!
- It simplified the whole process for staff
- It has had a positive impact on other aspects of care
- Something visual like a measles chart helps staff to get involved
- We took it in bite sized chunks and involved the whole team
- One of the tools helped me to fill in my post fall accident report form
- We saw things that needed to change when we otherwise would not have
Launched June 2011

Launched by Minister for Public Health June 2011 in Meldrum Gardens care Home, South Lanarkshire.
The resource

Comprises:

• Brief introduction to the topic of falls prevention and management prevention, and fracture guidance,

• the self assessment,

• information and tools to help improve care,

• guidance on making improvements,

_and comes with_

• a falls and fracture awareness DVD produced by NHS Lothian.
### Self Assessment

The sections within the self assessment are:

A. Supporting documentation,

B. Falls and fracture risk assessment and care planning,

C. Recording and reporting falls: gathering and analysing information,

D. Actions triggered by a fall,

E. Falls and fracture prevention interventions,

F. Service provision to the care home,

G. Education and training.

### Self assessment form

<table>
<thead>
<tr>
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<th>Date assessed</th>
<th>Date reviewed</th>
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<tbody>
<tr>
<td>A. Supporting documentation</td>
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<tr>
<td>1</td>
<td>There is written guidance on falls prevention/reduction, which includes reference to the involvement of local services with individual residents.</td>
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<tr>
<td>2</td>
<td>There is written guidance on the safe and appropriate use of equipment to prevent falls and injuries such as bedrails, lap straps, harnesses, specialist seating and hip protectors.</td>
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<td>3</td>
<td>There is written guidance on the use of low-profiling beds.</td>
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<td>4</td>
<td>There is written guidance on the use of assistive technology and alarms.</td>
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<td>5</td>
<td>There is written guidance on how to record, report and monitor falls.</td>
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<td>6</td>
<td>There is written guidance on immediate essential care when a resident has fallen or has been found on the floor.</td>
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<td>7</td>
<td>There is written guidance on further actions to be taken after a resident has fallen.</td>
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<td>8</td>
<td>There is written guidance on medication reviews.</td>
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<td>9</td>
<td>There is written guidance on sight and hearing tests.</td>
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<td>10</td>
<td>There is written guidance on diet, food and water intake.</td>
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<td>11</td>
<td>There is written guidance on pre-admission falls risk assessment (including bone health).</td>
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### B. Falls and fracture risk assessment and care planning

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<thead>
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<th>Date assessed</th>
<th>Date reviewed</th>
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<tr>
<td>1</td>
<td>The admission assessment includes a multifac torial falls risk assessment, using an agreed tool or proforma.</td>
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<td>2</td>
<td>The multifactorial falls risk assessment includes an osteoporosis risk screen.</td>
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<td>3</td>
<td>The multifactorial falls risk assessment has a linked care plan, tailored to the individual resident, which links any risks identified with suitable actions (for inclusion in the care plan).</td>
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<td>4</td>
<td>The multifactorial falls risk assessment and care plan are updated monthly and reviewed formally on a regular basis (for example, every six months or according to local policy).</td>
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<tr>
<td>5</td>
<td>The multifactorial falls risk assessment and care plan are updated after every fall.</td>
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<td>6</td>
<td>The multifactorial falls risk assessment and care plan are updated after any significant change in a resident's condition.</td>
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<td>7</td>
<td>The multifactorial falls risk assessment and care plan are updated on re-admission to the care home following discharge from another setting, for example discharge from hospital.</td>
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</table>
Section B - Falls and fracture risk assessment and care planning

This section outlines good practice in relation to falls and fracture risk assessment and care planning. It provides two examples of multifactorial risk assessments, which include suggested actions for the care plan.

Introduction

There are general measures you can take to reduce risk of falling and harm from falls for all residents of a care home. However, you must also consider each resident’s individual risk.
The toolkit - support improvements

- 21 tools linked to the 7 sections in the self assessment.
- They don’t all have to be used! **(Important message)**
- If some tools are used already in a care home, compare and contrast, choose ones required that will help improve care.
Tool 4: Resident environment and orientation check

This tool can be used as a prompt to consider environmental risks relating to the individual and their own room.

**Footwear/clothing**
- Is footwear lightweight and non-slip? Are clothes non-slip and correct length?

**Walking Aid/ wheelchair**
- Do they require a walking aid? Is their walking aid/ wheelchair clean and in a good state of repair?

**Flooring**
- Is the flooring in good condition and non-slip? Are all thresholds flush?
- Is there adequate space, free from clutter?

**Lighting**
- Is the lighting suitable for the resident's needs?

**Bathroom**
- Is the bathroom suitable for the resident's needs?
- Can the resident find it easily?

**Surrounding area**
- Are the hallways well lit and well signposted for resident? Is there easy access?

**Furniture**
- Is there adequate space for walking aid/ moving and handling equipment?

**Bed**
- Is the bed suitable for resident's needs?

**Consider?**
- Liaising with next of kin and discussing with resident the importance of suitable footwear and clothing.
- Checking footwear monthly.
- Provision of equipment eg long handled shoehorn, helping hand if required.

**Consider?**
- Referral to local physio department.
- Checking condition of walking aid, replace ferrules if required.
- Checking condition of wheelchair, arrange wheelchair repair if required.
- If tap belts are being used appropriately.

**Consider?**
- Reporting and recording any problems.
- Rearranging furniture if required.
- Encouraging good housekeeping.

**Consider?**
- Night light.
- Bedside light.
- Accessibility to resident.
- Additional lighting if required.
- Timer lighting if required.

**Consider?**
- Position of buzzer.
- Position of soap/hand towels.
- Using a raised toilet seat/toilet frame.
- Is there space for walking aid/ moving and handling equipment?
- Signage.
- Grabrails.
- Lightweight door.
- Contrasting colours.
- Position of bed.

**Consider?**
- Additional lighting.
- Additional signage.
- Floors different colour from walls.
- Adequate handrails.
- Cutter free.
- Reporting and recording any issues.

**Consider?**
- Rearranging furniture.
- Removing unnecessary furniture.
- Are footstools able to be moved and stored safely?
- Accessibility to:
  - buzzer
  - electrical equipment
  - wardrobes and drawers.

Consider?
- Height.
- Mattress suitability.
- Position in room.
- Accessibility and ability to use buzzer.
- Grab rails.
- Need for bed rails.

Adapted from a tool developed by Lynn Flannigan, NHS Lanarkshire
# Tool 7: Falls Management checklist

This tool can be used to check if falls prevention actions have been carried out. It can be used to check one area of the care home or on a random selection of residents.

Date of check: Please enter any comments on reverse page

(Circle appropriate response)

<table>
<thead>
<tr>
<th>Resident</th>
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<tr>
<td>1. Is the resident’s chair at appropriate height? (ie resident can sit on chair with feet resting on the floor) (for residents in wheelchairs; are footplates in use?)</td>
<td>Yes</td>
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<td>2. Is the resident’s bed in the low position? (even if resident is not presently in bed)</td>
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<td>3. Is the buzzer within easy reach?</td>
<td>Yes</td>
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<td>4. Can the resident access personal belongings at arms reach? (If resident able, ask him/her to reach for an item of personal belongings)</td>
<td>Yes</td>
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<td>5. Have all non-essential items which would impact on the resident’s safety been removed from their bedspace? (inspect bed space for ie cables/clutter)</td>
<td>Yes</td>
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<td>6. If the resident uses a walking aid independently – is walking aid within reach? (ask resident to reach for walking aid, if able)</td>
<td>Yes</td>
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<td>7. Are bedrails used when this resident is in bed?</td>
<td>Yes</td>
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<td>8. Is reason for bedrail use recorded in resident’s notes ie bedrail risk assessment? (Check with staff) note if used as restraint or moving &amp; handling aid</td>
<td>Yes</td>
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<td>9. Detail the reason for using the bedrails, ie sided weakness/resident requested</td>
<td>Yes</td>
<td>Yes</td>
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</table>
Tool 10b: Post fall/incident report form

Resident’s name: 

Date of birth: 

Room number: 

Date of fall/incident: 

Time of fall: 

**Fall location**
- Outdoors 
- Bedroom 
- En-suite 
- Bathroom 
- Corridor 
- Sitting room 
- Dining room 
- Exact location

**Surface type**
- Carpet 
- Linoleum 
- Other (specify) 

**Surface condition**
- Wet 
- Damaged 
- Slippery 
- Other 

**Bed position**
- High 
- Low 
- Tilted 
- N/A 

**Call bell in reach**
- Yes 
- No 
- N/A 

**Light**
- On 
- Off 
- N/A 

**Mobility**
- Ambulant 
- Non-ambulant 
- Independent 
- Assistance of 1 
- Assistance of 2 

**Aids**
- None 
- Stick 
- Walking Frame 
- Crutches 
- Wheelchair
Watched the DVD

Included parts of the resource pack as part of regular staff training

Written an action plan to address any gaps identified in the self assessment

Included parts of the resource pack as part of induction training

Completed the self assessment

Read the resource pack

Actions taken by care homes with the resource pack (N=334)

- **Read the resource pack**: 81.7% have done, 8.7% plan to do, 0.3% don’t plan to do.
- **Completed the self assessment**: 31.1% have done, 49.7% plan to do, 1.5% don’t plan to do.
- **Written an action plan to address any gaps identified in the self assessment**: 18.3% have done, 59.3% plan to do, 3.0% don’t plan to do.
- **Included parts of the resource pack as part of induction training**: 22.8% have done, 60.5% plan to do, 1.8% don’t plan to do.
- **Included parts of the resource pack as part of regular staff training**: 26.0% have done, 60.2% plan to do, 0.6% don’t plan to do.
- **Watched the DVD**: 73.7% have done, 13.8% plan to do, 0.6% don’t plan to do.
What actions have been identified as required (N=137)

- Provision of education and training: 82.5%
- Taking actions to prevent falls and fractures: 62.0%
- Undertaking falls and fractures risk assessment and care planning: 58.4%
- Recording and reporting falls: gathering and analysing information: 56.9%
- Taking actions triggered by a fall: 52.6%
- Preparation of supporting documentation: 48.2%
- Review of service provision to the care home: 45.3%
Percentage of respondents saying the resource pack has helped them (N=290)

- It has helped to personalise care in relation to falls management: 49.3%
- It has meant that we identified required actions that we hadn't considered before: 44.8%
- It has helped us to address required actions more easily: 41.0%
- It has meant that we looked at these issues sooner than planned: 38.6%
- It has helped us respond better following a fall / fracture: 29.0%
- It has helped us prevent falls / fractures: 21.7%
- It has made no difference to our approach to managing falls and fractures: 7.2%
How helpful the DVD has been

Raising awareness of the issues (N=148)
- 8.8% 1 (not very helpful)
- 21.6% 2
- 66.9% 4 (very helpful)

Changing practice / behaviour (N=132)
- 15.2% 1 (not very helpful)
- 28.8% 2
- 50.8% 4 (very helpful)
## Use of Good Practice Resource in England

### Falls from April to November 2011

<table>
<thead>
<tr>
<th>Month of fall</th>
<th>No. Of falls</th>
<th>No. of people who fell</th>
<th>reasons if known/likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011</td>
<td>28</td>
<td>13</td>
<td>mixture of reasons</td>
</tr>
<tr>
<td>May 2011</td>
<td>42</td>
<td>16</td>
<td>mixture of UTIs, infections, poorly</td>
</tr>
<tr>
<td>June 2011</td>
<td>17</td>
<td>10</td>
<td>mixture of infections, UTIs/poorly,</td>
</tr>
<tr>
<td>July 2011</td>
<td>6</td>
<td>5</td>
<td>3 UTI, 1 in garden, 1 poorly, 1 new</td>
</tr>
<tr>
<td>Aug 2011</td>
<td>7</td>
<td>7</td>
<td>2 UTI, 2 very poorly, 3 infections</td>
</tr>
<tr>
<td>Sept 2011</td>
<td>5</td>
<td>5</td>
<td>2 chest infections, 1 UTI, 1 slip, 1 trip</td>
</tr>
<tr>
<td>Oct 2011</td>
<td>6</td>
<td>6</td>
<td>4 UTIs, 1 trip, 1 poorly</td>
</tr>
<tr>
<td>Nov 2011</td>
<td>2</td>
<td>2</td>
<td>1 trip, 1 not witnessed</td>
</tr>
</tbody>
</table>
Managing falls and fractures in care homes
Southside Nursing Home, Inverness (33 residents)

• Carried out the self assessment.

• Collected data that told a story.

Made simple changes, such as:
  Reviewed risk assessment process.
  Hospitality workers at ‘peak’ falls times.
  Improved lighting at night.
  ‘Relocating’ staff on night shift.

Halved falls in one year (2011/12: 4-10 falls/month; 2012/13: 1-4 falls/month).
..a national project...

Up and About in Care Homes
The Management of Falls and Fractures in Care Homes for Older People Improvement Project
Why do we need to do this work?

• Older people living in care homes are **three times more likely** to fall than older people living in their own homes, there are **ten times more hip fractures** in care homes than in other environments.

• The rate of emergency admissions due to falls in people aged over 65 is almost **four times higher** than among older people living in their own homes. The cost of these admissions is estimated to be in the region of **£22 million**.

• There is evidence emerging that **falls have reduced by up to 50%** in care homes where the resource has been **adopted with support from the Care Home Manager and the wider health and social care team**.

• Following the evaluation the **Care Inspectorate** and the **National Falls Programme** agreed to work with care homes, falls leads and others to explore options for local implementation support.
What is the approach?

**Phase One** (December 2013 to August 2014)

- Working with a limited number of care homes, explore how best to support care home managers and staff to use the resource to make and sustain necessary improvements using a collaborative approach.
- Facilitating partnership working with the wider health and social care team locally - an essential part.
- Build on examples of tried and tested changes care home staff have made that have clearly improved the care of older people at risk of falling.

**Phase Two** (to be confirmed)

- The learning from Phase One will inform the second phase, which aims to provide support on a larger scale.
Who is involved?

• The Project is sponsored by the Scottish Government (Jacqui Lunday Johnstone, Chief Health Professions Officer).

• Part of the National Falls Programme (Ann Murray, National Falls Programme Manager).

• National partners include the Care Inspectorate (Edith Macintosh, Rehabilitation Consultant), the Joint Improvement Team and Scottish Care.

• Three Partnership areas: West Dunbartonshire, North Highland and Dumfries and Galloway.

• Up to 15 care homes in each area, across a range of sectors.

• National project team
  – Project Lead: Lianne McInally
  – Deputy Project Lead: Lynn Flannigan
  – Improvement Advisor: Amaia Ibanez de Opacua
  – Administration Officer

• Local Team, including
  – Project Falls Lead/s
  – Health and Social Care Teams
  – Care Inspectorate

• Expert Advisory Group
Core support for all participating care homes

1. Mentoring for self assessment and action planning.
2. Introduction to measurement for improvement.
3. Building the local team.
4. Learning sessions (2) and network participation.

Learning sessions (to be held locally)

- Teams from each participating Care Home will be invited to attend along with representatives from the wider health and social care team.
- At the first Learning Session (Feb/March 2014) the project team presented ideas for change.
- The teams were taught how to use improvement tools to enable them to test the suggested changes locally.
- Participants learned about the importance of managing falls and fractures and have time to familiarise themselves with the resource pack.
- At the second Learning Session, team members learn more from one another as they report on successes, challenges, and lessons learnt.
Additional support

Other support options may include (dependent on self assessment findings):

• Falls awareness training.
• How to use multifactorial falls risk assessments and care planning.
• How to maintain a safe environment.
• Setting up strength and balance exercise sessions.
• Personal footcare training.
• Promoting physical activity (Go for Gold Challenge).
• Use of telecare.

Focus on sustainability and building local capacity and capability.
What do we hope to accomplish?

• Care Home Managers and staff will gather and analyse data to enable them to understand and address the causes and patterns of falls within the care home.

• To improve the **reliability** of safe, effective and person centred care to prevent falls and fractures in care homes using *Managing Falls and Fractures in care Homes for Older People*.

• To improve **reliability** of safe and effective care and intervention following a fall.

• To deliver person and family centred care to reduce the risk of falls and fractures and increase physical activity.

• To work towards embedding an infrastructure and culture that promotes high quality, person centred care - sustainability.
Big aim!

To reduce the number of falls in participating care homes by 50% by the end of 2015.
## UP and ABOUT COLLABORATIVE MEASURES

<table>
<thead>
<tr>
<th><strong>OUTCOME MEASURES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of falls in care home or days between falls.</td>
</tr>
<tr>
<td>2. Percentage of residents who have had a fall/falls.</td>
</tr>
<tr>
<td>3. Number of Emergency Department attendances secondary to a fall.</td>
</tr>
<tr>
<td>4. Number of Scottish Ambulance Service attendances secondary to a fall.</td>
</tr>
<tr>
<td>5. Number of emergency admissions secondary to a fall.</td>
</tr>
<tr>
<td>6. Resident/carer experience (Quality of life)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PROCESS MEASURES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Percentage of residents with completed falls risk assessment on admission.</td>
</tr>
<tr>
<td>8. Percentage of residents with completed falls risk assessment following a fall or change in medical status</td>
</tr>
<tr>
<td>9. Percentage of residents with an up-to-date documented fall/injury reduction plan</td>
</tr>
</tbody>
</table>
Over to you!

Take some time to look at the tools on your tables and consider what you have heard.

Discuss:

Would it be useful to carry out a self assessment in a care home/care homes in your area?

What realistic support could be available for care homes in your area to do this and complete a charter/action plan for improvement?

What next steps could you/your team take over the next 6 months to support improvement and help to manage and reduce falls and fractures in care homes in your area?
New resource for Scotland

To promote physical activity in the care sector...
Based on 3 key principles with 3 improvement areas

A Physical activity participation
1. Voices and choices
2. Promotion
3. Everyone’s business

B Organisational care home culture and commitment
1. Leadership, management and support
2. Enabling environments
3. Staff training and support

C Community connections and partnerships
1. Advice, skills and guidance
2. Access to places and spaces
3. Families, friends, volunteers and others
Resource booklet
### Self-assessment process

#### Self-assessment tool: principle A – physical activity participation

<table>
<thead>
<tr>
<th>Area for Improvement: All Voices and choices</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents have physical activity choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>documented in their care plans. They are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regularly invited to take part in daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>life as they wish choose.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Examples of evidence                        |     |    |
| Choices and outcomes are written in resident |     |    |
| care plans.                                  |     |    |
| Physical activity plans are updated at both |     |    |
| formal and informal.                         |     |    |
| Residents (where appropriate) are able to   |     |    |
| say they are enabled to be physically active. |     |    |

**Name:**

**Date:**

**Signature:**

**Review date:**

#### Self-assessment tool: principle B – organisational care home culture and commitment

**Area for Improvement: B2: Enabling environments (both inside and out)**

<table>
<thead>
<tr>
<th>Standard statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>provides an active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lifestyle for all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>residents, through</td>
<td></td>
<td></td>
</tr>
<tr>
<td>offering opportunities to be physically active and promoting the use of the gardens, play areas and those in the care home.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of evidence</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy in place for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals, activities and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recreation are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>widely accessible for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>all residents and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff and residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>have the opportunity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and are encouraged to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>be physically active.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Care Standards: 13/14, 15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name:**

**Date:**

**Signature:**

**Review date:**

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Make Every Move Count

MESSAGE 1:
GET TO KNOW ME, WHAT MOTIVATES ME, SUPPORTING ME TO MOVE WITH PURPOSE
- Know what I can do now, would like to be able to do, and support me to do it.
- Know my likes, dislikes, interests, and what is important to me.
- Know what will make a difference to my day and will motivate me to be more active.
- Know what will fit easily into my day.
- Know how to do it with me, not to or for me, giving me control and independence.

MESSAGE 2:
SUPPORT ME TO MOVE SAFELY WITH CONFIDENCE
- Support and encourage me to be independent with my daily tasks like washing and dressing.
- Support and encourage me to move from my bed to my chair or from my chair to stand up.
- Regularly break up the time I spend in bed or sitting in a chair.
- Support and encourage me to move around and meet people.
- Support and encourage me to be strong and steady, to feel safe and go at my own pace.

MESSAGE 3:
SUPPORT ME TO MOVE MORE OFTEN AND BE MORE ACTIVE EVERY DAY
- Make it easy for me to take part in daily life such as meal times, outings and social events.
- Support me to be involved in daily life doing things like watering plants, setting the table or sweeping up leaves.
- Make sure I can continue hobbies such as gardening, painting and music.
- Make it easy for me to help others in different ways such as meal times, doing the laundry or DIY tasks.
- Find ways that I can have a part to play in daily life to help me stay connected.

A GUIDE FOR YOU WHEN SUPPORTING ME
1. Get to know me, what motivates me, supporting me to move with purpose.
2. Support me to move safely with confidence.
3. Support me to move more often and be more active every day.
4. Support me to move regularly and frequently.
5. Support me to move, giving purpose and meaning to my day.

SIGNPOSTS TO USEFUL INFORMATION
- www.scie.org.uk
- www.btfactive.org.uk
- www.active-ageing-events.org.uk
- www.napa-activities.co.uk
- www.scottishcare.org
- www.ageuk.org.uk/Scotland
- www.careinspectorate.com

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Call to action poster and a DVD

This care home is committed to make every move count!

All physical activity makes a difference – not just planned exercise. There are simple, easy ways to support the people you care for to be more active in their daily life. The 'Care... about physical activity' resource pack shows you how.

Support me to move...

...giving purpose and meaning to my day

...regularly and frequently

...safely with confidence

...more often and be more active every day

Get to me, motivate and support to move with purpose

www.careinspectorate.com
Follow us @careinspect

Care... about physical activity
Thanks for listening....

Any questions?