

Management of Slips, Trips and Falls Policy Inclusive of the EFH Post Fall Protocol

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Assessing needs

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

Delivering evidence-based care and treatment

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Monitoring and improving outcomes

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Scope

The purpose of this policy is to reduce, as far as practicable, the risk of slips, trips and falls for residents within EFH. Residents will receive a Falls Risk Assessment through completion on Access and Clinical within six hours of admission

and monthly reviews thereafter or following a slip, trip or fall. this will ensure all residents have a falls prevention and intervention care plan.

The Policy details the requirements for this.

This policy should be read in conjunction with:

- HSP01 Accident Reporting Policy
- HSP07 First Aid Policy
- HSP13 Falls from Windows Policy
- HSP21 Moving and Handling Policy
- HSP24 Preventing Falls From Beds Policy
- Management of Falls Policy
- Head Injury Policy
- NEWS2 and Clinical Observations Policy

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

Definition

The following definitions apply:

Slip: A slip is to lose one's footing and slide unintentionally for a short distance, causing the person to lose their balance; this is either corrected or causes a person to fall. (Oxford English Dictionary, 2017).

Trip: A trip is to catch one's foot on something and accidentally stumble or fall, often over an obstacle, causing the person to lose their balance. This is either corrected or causes the person to fall (Oxford English Dictionary, 2017).

Fall: A fall is defined as an event whereby an individual unexpectedly comes to rest on the ground or another lower level (World Health Organisation, 2016). This includes falls from height e.g. beds, chairs or other equipment being used in the course of routine patient care.

A Falls Risk Assessment: An in-depth and possibly on-going process of identifying falls risk factors that can be treated, managed or improved during the individual residents stay, with the aim of reducing the residents risk of falling in the home. This Risk Assessment is currently located on Access and Clinical Forms.

EFH will ensure:

Identification and treatment of any injury, including comfort, reassurance and pain relief where necessary.
Recognition and track and trigger/signpost of any physical deterioration using NEWS2 National Early Warning Score /Neurological (Neuro) obs.

The Policy

Falls Risk Assessment and Interventions

It is essential that the homes environment within the resident's room and general home environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect resident's risk of falling is systematically identified and corrective action is taken.

A Falls Risk Assessment should be undertaken for all residents within six hours of admission and reviewed at least monthly or immediately after an incident. This will be completed using the Access and Clinical Falls Risk Assessment form and a care plan developed following this.

Residents sustaining a recent fall or considered at high risk of falling will have an initial assessment of immediate risks to their safety in their room environment and where possible be referred to an appropriate professional or community team who will assess the patient for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. This assessment should be performed by a healthcare professional with appropriate skills and experience.

Any resident that has fallen once during their residence at EFH will be referred to an appropriate Falls Team, Care Home Support Team or GP / ANP.

Risks identified within the resident's room should form part of the Falls Risk Assessment and any interventions should be implemented without delay.

Staff should refer to the Falls Risk – High/ Medium and Low and make their assumptions that this is the correct level of risk for the resident based on the number / frequency of falls.

Immediate Management of Residents Who Have Fallen

Post Fall Protocol (Witnessed and Unwitnessed)

All staff employed at EFH must be aware of the Post Fall Protocol.

This protocol includes all elements included in NPSA RRR/2011/RRR001

This post fall protocol and the completion of the post fall check list must be included in the local induction of all staff by their line manager.

Staff who have come across a fallen resident (Unwitnessed Fall) must seek help from appropriately trained colleagues if they do not feel confident themselves in handling any aspect of the situation.

Staff must report the fall in accordance with EFH Reporting of Incidents Policy

Following a resident falling nursing staff must review why that resident has fallen and must take action to reduce the residents risk falling again. This process must be clearly documented in the residents Falls Risk Assessment record.

If the resident has more than one fall and a continued history of falls and where available, requesting the opinion of relevant expert therapists, nurses or medical staff attached to the Community Falls Lead as appropriate.

Staff should have access to appropriate equipment to assist residents safely up from the floor and that moving and handling training content enables staff to get residents safely up from the floor.

Staff who have come across a fallen resident must assess the resident according to the Post-fall protocol, If there are any "Red Flags / Clinical Indicators" indicating possible head injury, spinal injury, limb fracture or significant other injury (e.g. haemorrhage, large skin tears or lacerations), then the staff must call an ambulance.

Staff must report the fall in accordance with EFH Reporting of Incidents Policy.

Staff should also inform the Manager on call outside of working hours and in the event of a serious injury the Senior On Call Manager.

Following a serious injury resulting from a fall completion of Safeguarding report and Care Quality Commission Notification of a Serious Injury must be made without delay.

Following a serious injury resulting from a fall advice should be taken from EFH Health and Safety Adviser and a Route Cause Analysis may be undertaken.

Post Fall Protocol

Should the resident be discovered by an unqualified member of staff they should follow the emergency procedure and summon help.

The incident must be referred to the Registered Nurse in charge, or if in a residential setting to a Senior Carer or Head of Care.

Initial assessment

Ensure the resident is safe from harm and use the emergency bell to call for assistance as required.

Assess resident for any obvious signs of physical injury, including signs of fractures.

Signs of lower limb fracture might include:

- New deformity
- Pain
- Bruising
- Shortening of the leg
- The leg facing outwards

There might also be other signs therefore this is not an exhaustive list.

Signs of a spinal injury might include:-

- Altered sensation in the limbs like numbness or tingling
- Inability to move limbs
- Problems with coordination
- Loss of bladder / bowel control
- Twisted head / neck / back position.

There might be other signs therefore this is not an exhaustive list.

IF EITHER FRACTURE OR SPINAL INJURY SUSPECTED DO NOT MOVE RESIDENT

Summon an emergency ambulance by calling 999

Ensure the nurse or Senior Carer calling the ambulance states clearly to ambulance control that spinal injury or lower limb fracture is suspected and that you have not moved the resident.

Commence observations: temp, oxygen saturations, pulse, blood pressure, respiratory rate and [if indicated] blood sugars.

Take measures to maintain privacy and dignity.

Proceed to check for head injury as in post falls protocol.

Guidance on head injuries

Suspect head injury if:

- Fall unwitnessed
- Vomiting/Nausea
- Headache
- Altered consciousness
- New dizziness
- Head pain or tenderness or visible trauma
- New speech disturbance
- Double vision

Neurological observations (Neuro obs) should then be commenced, & recorded on the appropriate chart.

Neuro obs must include:

- 15 point Glasgow Coma Scale
- Pupil size and reactivity
- Limb movements / muscle power

Neuro obs must be done:

- Every 30 minutes for 2 hours
- Then hourly for 4 hours
- Then 2 hourly for a further 4 hours.

IF GCS LESS THAN 15, OR PUPIL SIZE AND/OR REACTIVITY ABNORMAL INITIALLY THEN CALL 999 EMERGENCY AMBULANCE

DO NOT MOVE RESIDENT.

CONTINUE ALL OBS. IF GCS CONTINUES TO DETERIORATE THEN KEEP AMBULANCE CONTROL INFORMED.

INCREASED RISK OF BLEEDING

Ensure immediate medical review (at the Emergency Department if needed) for all residents with head injury or unwitnessed fall if they have a history of:

- Bleeding
- clotting disorder
- currently on anticoagulants

Anticoagulants can include:

- Warfarin
- Low molecular weight Heparin
- Dabigatran (Pradaxa)
- Rivaroxaban
- Apixaban

Antiplatelet therapies include:

- Clopidogrel
- Aspirin

Following a fall and ongoing neurological observations

IF GCS DETERIORATES TO 13

CALL 999 FOR AN AMBULANCE IMMEDIATELY.

The Registered Nurse on duty (or person in charge in a residential home) will give a clear account of the accident to emergency services, noting the time, date and relevant medical history found within the resident's care plan.

The Registered Nurse on duty (or person in charge in a residential home) must be available to hand over details of the resident's condition, observations and any treatment given, along with the relevant paperwork to the paramedic team. Under no circumstances, other than at a solely residential home, must care staff hand over the information. The 'transfer of care' form and the DNACPR form must go with the resident and a Print of EMAR sheet.

Inform the resident's family or next of kin of the resident's condition and pending hospital admission.

Ensure a member of staff accompanies the resident to hospital.

The clinical decision for any deviation from this protocol must be documented.

Ongoing observations

Changes in neurological status can be rapid, dramatic or subtle, developing over minutes, hours or days, depending upon the injury sustained. Therefore the frequency of neurological observations will depend on the resident's condition and the rapidity with which changes are occurring or expected to occur.

Review frequency of observations with the Clinical Care Manager, Head of Care or Registered Nurse in charge after instructions as above.

Document in care plan and accident form observing following questions:

1. Was the resident unconscious?
2. Does the resident show any physical signs of head trauma (abrasions, bruising, and swelling)?
3. Does the resident show any signs of confusion?
4. Is the resident complaining of a headache?
5. If a head injury is suspected do not administer analgesia until a GP is notified (as this can mask the extent of a head injury).

Notify a GP if observations are stable and the Registered Nurse (or in a residential home the person in charge) on duty has no further concerns.

Document who was notified with the time and date in the care plan.

Ensure any fall resulting in a suspected head injury is reported to the General Manager.

The General Manager must ensure that the Senior Manager is aware of the fall and a hand over of the outcome must be given.

If the fall occurs while the resident is outside of the home. There must be consideration to the possible best interest of moving the resident to a place of warmth and safety to prevent e.g. Hypothermia

Managing Compliance

EFH will ensure compliance with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12

EFH Management of Slips Trips and Falls Policy Including Post Fall Protocol

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

It is the responsibility of the General Manager to report falls without delay and compile monthly audit of falls both witnessed and unwitnessed with the appropriate analysis of risk and trends together with interventions made to reduce risk.

It is the responsibility of the General Manager to report this information to:

- Monthly Heads of Department / Health and Safety Meeting
- Monthly reports to Health and Safety Advisor for EFH
- Monthly reports to Operations Manager for discussion at SMT.

Training

All staff through induction and annual training will receive information in the management of Slips, Trips and fall.

Staff training will include:

- Preventing Falls from beds.
- Preventing Risk of Entrapment
- Manual Handling Training
- Incident Reporting

Care staff are provided with training regarding Emergency First Aid / Management of a Head Injury at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of Emergency Procedures of a resident where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

Review date	Next Review Date
May 2024	May 2027