STOPFALLS

Falls Triangulation Checklist

Version 0.1 | 30-08-23

Hertfordshire

Introduction

The individual falls care plans should contain all of the relevant documentation for each person, including risks and interventions that need to be put in place, and there should be links that cross-reference the falls care plan to ALL relevant parts of the care plan - this is called 'triangulation'.

These may include: eating/drinking/activity levels/movement/ eyesight/clothing and footwear etc. and should also include things like: Are they losing weight; do they have low hydration levels; are they more withdrawn; and are they more sedentary for any reason.

There are many falls risk factors, please use the **HCPA Multifactorial Risk Assessment** and Guidance to ensure all factors have been considered.

Download the risk assesment form

Contents

1. Overall health of residents:

Acute illness or infection

Are staff confident with signs of deterioration?

- New Confusion/Delirium (NB: This is a confusion that is NOT USUAL for that person, (i.e it could be different from their usual confusion, if they have a condition such as dementia).
- This could be due to an infection (chest infection, wound infection, UTI etc), as well as the result of dehydration.

STEP 1.

Identify individual signs

Are the staff identifying infections correctly and in a timely way?

- Even if they do not notice a new confusion, do they notice other signs of an infection?
- Generally, these may include: behaviour that is different from usual. The person may be less talkative, or less engaged, or they may not do the things they normally do; increased tiredness/ fatigue; reduced mobility, paleness/redness in the face, hot and clammy skin, mottled skin, shivering.
- Specifically, in addition to the general signs, for a chest infection, these may include: Shortness of breath, increased use of the upper shoulders than usual when breathing; faster or slower breathing, anxiety; changes in secretions (increased amount, increased thickness or a change in colour - if the person usually has secretions); audible crackles or wheezes; smell of chest infection.
- Specifically, in addition to the general signs, for a UTI, these may include: dark or cloudy urine; blood or sediment in the urine; urgency and/or frequency of urine that is not usual for the person; a change in urine output; pain on urinating or in the abdominal area (this may be indicated by pain behaviours, such as a reluctance to go to the toilet, or behaviours that are specific to the person, such as rocking/ hitting out); smell of UTI.
- Specifically, in addition to the general signs, for a wound infection, these may include: Wound exudate changes, foul smell of wound infection; increased swelling/redness/pain.

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1. Overall health of residents: (continued)

STEP 2.

Appropriate and timely intervention

What tools are they using to do this? Is the service using the NEWS/RESTORE tool for prevention of hospital admissions?

- Use NEWS2/RESTORE2 to establish how unwell the person actually is, and to monitor them and to escalate as necessary.
- What interventions are put in place?
- Is there evidence of each episode and of potential signs for each person in the risks section of the falls care plan?
- Is there evidence of preventative strategies, for example, if there has been an increase in UTI's, how is fluid is being increased/monitored etc?
- Are the staff monitoring hygiene?
- Are there appropriate referrals to SALT/999 and is there evidence of this in the care plans?
- Are the staff encouraging movement and activity?
- Is there evidence of triangulation of monthly reviews and data related to chest infections, pressure sores, and falls, to identify potential patterns and trends, root causes and risks?
- Have measures that have already been implemented prevented a fall from happening, and what interventions are there planned for further prevention?

Chronic deterioration (i.e. non-acute illness)

- Are there monitoring processes (and documentation) in place, that are updated monthly, as well as when necessary, for: weight, food and fluid intake, continence, effects of medication, effects of disease processes, pressure sores, activity levels, mobility and balance, participation in exercise (classes/1:1 sessions), ability to participate in Activities of Daily Living (ADLs), mood, mental health, visual/hearing impairment, as well as concerns/risks regarding any interventions that have been implemented so far - such as sensor mats that the person simply walks around?
- Fear of falling is a huge risk factor for falls. Are there goals in the care plan, plus strategies to monitor and achieve those goals, aimed at increasing people's confidence and ability?
- Are individuals taking Vitamin D to support with bone health? This is evidenced to support falls prevention: academic.oup.com/ageing/article

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2. Patterns/trends:

Times of the day

What is going on at the service and when?

Source: https://www.dementiauk.org/get-support/understanding-changes-in-dementia/sundowning/#managing

- Evening falls – Are people looking for food? Is there enough food around for people to eat, especially if they have only had a sandwich at 5.30pm?
- We know that activity staff often leave work in the afternoon. What is the service doing to support people who may be distressed in late afternoon and evening?
- Staffing levels on the units where there are higher falls. Is there a case that should be made for more staff e.g. for twilight shifts, or for someone who needs 1:1 care?
- There should be evidence of management strategies that are in place to manage 'sundowning'. Do staff use distraction techniques - for example: take the person into a different room, make the person a drink, give them a snack, turn some music on, or go out for a walk with the person?
  - Do they ask them what the matter is? And listen carefully to their response and if possible, deal with the reason for their distress?
  - Do they talk in a slow, soothing way?
  - Do they speak in short sentences and give simple instructions to try to avoid confusion.
  - Do they hold the person's hand or sit close to them and stroke their arm.

Bed prevention and unwitnessed falls

- Is there evidence of how people are being encouraged to be out of bed? - Is HCC's Bed Prevention Tool being used for people who are cared for in bed?
- Have staffing levels been considered? There should be emphasis on having appropriate levels of staff that encourage people out of bed.
- Many falls are unwitnessed because the person is alone in their bedroom. Do falls interventions include what is being done to encourage people out of their rooms. How are staff preventing loneliness and isolation? Are unwitnessed falls being documented appropriately (using the HCPA's Falls grading scale).
- Are unwitnessed falls being tracked to establish patterns/potential causes and what is being trialed to reduce the likelihood of this happening?

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3. Physical activity & movement:

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Monitoring

- Is the service looking at how much/often someone is moving? Why might they not be moving? Is it fear/confidence/pain etc?

Referrel and eductation

- Is there an Enabling and Mobility Champion?
- Are appropriate referrals being made to Physiotherapists for mobility assessments and mobility aids assessments?

Exercise

- Is there structured exercise?
- Is there a Chair Based Exercise Instructor? Are there regular classes taking place? If there is a chair-based exercise instructor – are they doing 1:1 with individuals who need to improve mobility and strength?

Everyday activity

- Is there evidence of being risk positive, to ensure that an individual has the opportunity to improve, even where there may be a risk of falling? And are these risks being managed (and documented) appropriately?
- Are activities of daily living being monitored as part of everyday activity?

Practice mobility and balance

- Staff often say they don't get time to walk with an individual. Is there time for staff to support people to mobilise?
- Are staff practicing mobility with individuals? An example of this for someone who is recently 'back on their feet', or who staff feel is particularly at risk of falls, is: walking with 3 members of staff, 1 with a wheelchair behind the resident and a member of staff either side.
- Are individuals practising balance? If they are not qualified to deliver a structured balance exercise session, then are they at least practising balance with everyday tasks or with 1:1 balance exercises? These are available on the HCPA Stop Falls app.

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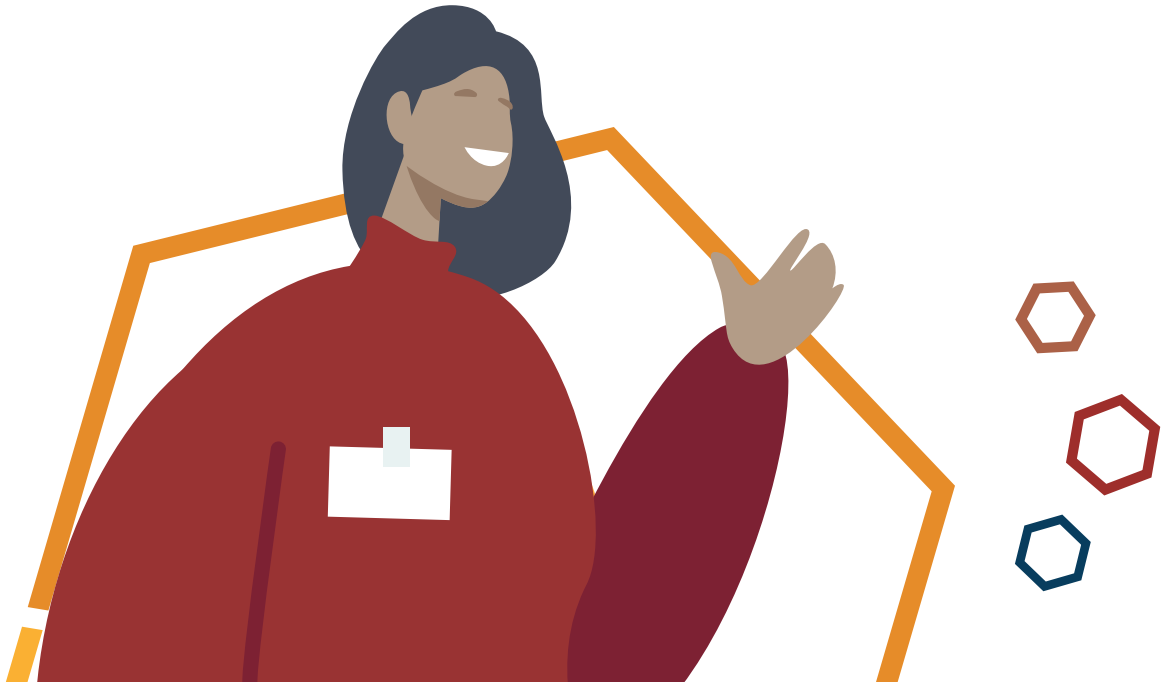
4. Equipment:

Referral	● Are appropriate referrals being made to Physiotherapists for mobility aids assessments? ● Are appropriate referrals being made to Occupational Therapists (OTs) for other equipment?
Audits	● Is it safe to use? ● Is it the right equipment for the individual?
Education	● Are staff up to date in Moving and Assisting Training? Do they have an in-house Moving and Assisting Trainer? HCPA offer Moving and Assisting Train the Trainer and CPD sessions for existing TTTs.



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5. Dementia & engagement:

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Types of dementia

- It is common that falls are common with people living with Dementia. We want to ensure that staff understand different types of dementia as this will affect people in different ways.
- Is there evidence that staff consider 'ability', rather than 'disability'?

Behaviour

- Are there positive behaviour support plans? Does the service need training in this topic? Is the home using reminiscence, music, meaningful activity?
- Are reminiscence and life stories being used to support individuals? Examples may be life story albums/books and meaningful conversations.

Sundowning

- What is going on throughout the day? Are there activities? For residential services we know that commonly activity staff go home in the afternoon. What is the service doing to support people who may be distressed at this time?
- Are provisions made for changes in eating and drinking habits? Is there finger food available where needed?

Equipment

- Are there strategies in place for individuals who forget to use their frames? Could fixing up frames, adding colour, be tried? Ensure this is still person-centered, risk assessed, and is added to falls care plans.

Activity levels

- Is there a focus on activities of daily living and independence?
- Are activity levels/ levels of engagement being monitored and evaluated during the day? Is there evidence about how this impacts on the person's mental and physical health?
- Is there awareness of community involvement, exercise classes, Dementia café's and Day centers?

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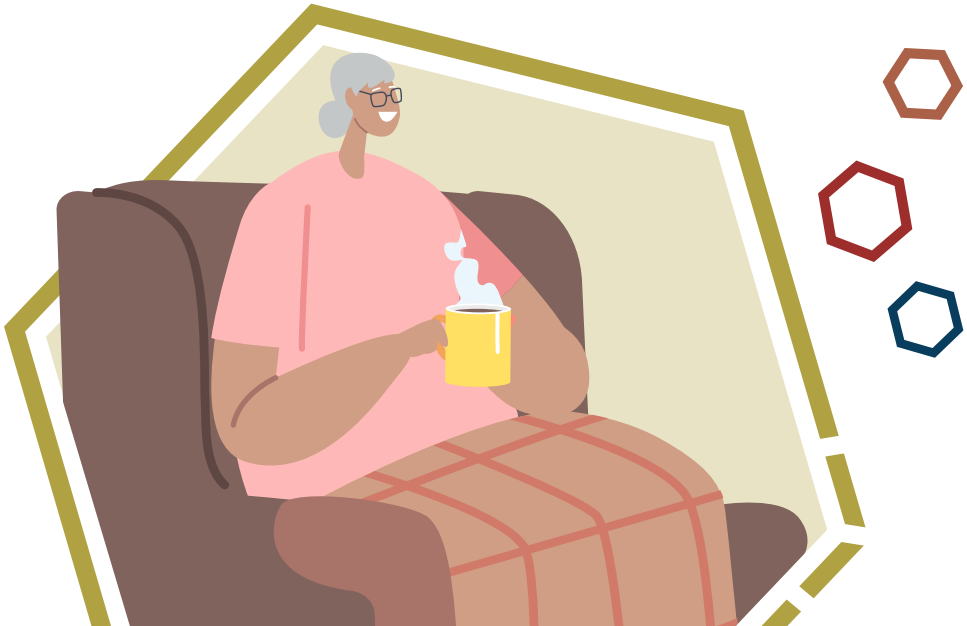
6. Next steps:

Communication & lessons learnt

Culture	● Is there a questioning approach within the staff teams, so that they are solution-focused and get to the cause of the problem?
Referral	● Is there evidence of referral to Multidisciplinary Team and Allied Health Professionals?
Information sharing	● Are those who are at risk of falls being discussed in staff meetings/MDTs? If you have champions, are they working together to evaluate individuals? Are interventions discussed?



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6. Next steps: (continued)

Education & resources

Assessments

- Using HCPA's Multifactorial Risk assessment and guidance
- Prevention and Enablement Framework – to evidence how you are use prevention and enablement within your service.

Falls management

- Management of when somebody has fallen in a care home pathway

Education

- Chair-based Exercise Instructor
- Enabling and Mobility Champion
- Falls and Frailty Champion
- Falls prevention

Resources

- HCPA StopFalls app
- HCPA StopFalls website resource library - Visit our resource page
  - An Enabling Care Approach - Click to download pdf
  - Sit less, Move More - Click to download pdf
  - Staying Healthy at Home - Click to download pdf
- Safeguarding and falls practice guidance

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