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Falls – Prevention and Risk Management Policy

HP118 Homes Policies

June 2024

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1. Introduction

Falls and fall related injuries are a common and serious problem for older people who have the highest risk of falling. Reducing falls and potential serious injuries are important for maintaining health, wellbeing, and independence amongst the people in all MHA services.

Older people living in care homes are three times more likely to fall than older people living in their own homes, with the results of these falls often being more serious. Many factors can contribute to this heightened risk, such as physical frailty, the presence of long-term conditions, physical inactivity, taking multiple medications and the unfamiliarity of new surroundings. However, in many cases taking the right steps at the right time can actively support an individual and reduce the risk of falls and harm from falls.

1. Scope and Purpose

This policy and associated documents, procedures and guidance have been developed in accordance with MHA’s Falls Prevention Strategy, national guidance, and relevant legislation, underpinned by evidence-based practice and providing clear guidance for the assessment, prevention, management, and reporting responsibilities of all falls and falls related incidents.

* 1. This policy, procedures and guidance applies to all colleagues, volunteers and temporary personnel who have responsibility for safely supporting people in all MHA services.
  2. The purpose of this policy document is to:
  + Raise awareness amongst all colleagues for the need for falls assessment, prevention, and management
  + Reduce the risk of falling by means of a falls risk assessment and implementation of appropriate interventions for falls prevention
  + Standardise post falls interventions to reduce the risk of injury
  + Provide reporting procedures with defined colleague responsibilities for monitoring incidents within MHA’s governance framework

1. Definitions

|  |  |
| --- | --- |
| Term | Definition |
| **Slip** | 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 |
| **Trip** | To catch one’s foot o something and accidentally stumble or fall, often over an obstacle, causing the person to lose their balance.  This is either corrected or causes a person to fall |
| **Fall** | Is defined as an event which results in a person coming to rest inadvertently on the ground or floor. This is differentiated from a person who is observed to willingly place themselves on the floor |
| **Multifactorial Falls Risk Assessment**  **(MFRA)** | An assessment with multiple components that aims to identify a person’s risk factors for falling [HP118b] |
| **Orthostatic Hypotension** | A drop in blood pressure (BP) on standing a common occurrence in individuals who are unwell and a risk factor for falls (refer to resources, section 10 for nursing homes) |
| **RIDDOR** | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013  If an incident is suspected to fall within the criteria of RIDDOR MHA’s health and safety team should be contacted for advice |
| **Hazard** | Any source of potential damage, harm, or adverse health effects |

1. Falls Risk Management - Standard Operating Procedures

This section focuses on the prevention of falls and outlines good practice relating to falls and fracture risk assessment and falls support planning. By completing the Falls Preadmission Questionnaire [HP118a] and Multifactorial Falls Risk Screen (MFRS) [HP118b] risk factors can be identified, and action taken to remove or reduce risk where possible

Key things to remember:

* A fall is nearly always due to the presence of one or more risk factors.
* A person-centred approach should be taken to MFRA and falls support planning.

The emphasis should always be on anticipating and preventing falls rather than simply managing falls once they have occurred.

Preadmission Questionnaire

* + 1. All individuals admitted should have a Falls Preadmission Questionnaire completed [HP118a], ideally within 2 weeks of admission and included with the general preadmission assessment or on day one if unable to complete pre-admission

Multifactorial Falls Risk Assessment

The Multifactorial Falls Risk Assessment includes the identification of the following risk factors in accordance with NICE guidelines:

* + identification of falls history
  + cognitive impairment
  + continence problems
  + footwear
  + medication
  + visual impairment
  + balance mobility problems
  + environmental factors
  + health problems including a diagnosis of osteoporosis
    1. All individuals must have a Multifactorial Falls Risk Assessment (MFRA) completed on the first day of admission or day 5 if no history of falls has been identified in the preadmission questionnaire, including people being admitted for respite.
    2. The MFRA must be reviewed and updated monthly or in the following circumstances
  + after every fall
  + after a hospital admission
  + when the individual’s environment is changed e.g., move rooms or bed
  + position
  + when there are any significant changes in an individual’s health which may

impact on their mobility, including medication changes

* + 1. This risk assessment should inform the individuals falls support plan which should include any safeguards to be put in place following the identification of risk.
    2. Where falls safety equipment is required the risk assessment should include details of what type of equipment, when to use and where to position
    3. All appropriate referrals should be made at the initial assessment stage and at subsequent reviews. The individual (and their family where appropriate) should be involved as much as possible with the assessment and any falls prevention strategies which can be followed.

Support Planning

The falls support plan will focus on enabling and empowering the individual to keep active while minimising the risk of falling. It should take into account the importance of choice, rights, independence, and personal outcomes for an individual at all times. Any support required should be clearly recorded.

It is essential that a person-centred approach is taken to falls prevention and management and fracture prevention. The individual’s values, preferences, wishes, routines, likes and dislikes should be central.

* + 1. A falls support plan is a working document, which you review monthly and update regularly following the initial MFRA, continually identifying and responding to any falls, change in the resident’s condition or care needs.
    2. If possible, colleagues must involve the person in the support planning process. Colleagues must explain the process to the person so that they understand the reasons there are lots of questions, having lots of discussions, and taking time to get to know the person and their representatives. A person’s support plan must be reflective of their needs at any given time.
    3. If falls safety or sensor equipment is being used, the Falls Equipment Check Record [HP118d] must be referred to in the support plan and commenced to record a visual check completed at each point of care
    4. For a person who lacks capacity, colleagues must –
  + involve them as much as reasonably possible in the process.
  + record all details in the relevant support plan with regard to responses to any falls assessments and interventions i.e., lying and standing blood pressure check (nursing)
  + speak to and involve their family but remember that the only person with any legal right is the person’s Lasting Power of Attorney (LPA) for health and welfare
    1. Refer to Falls and Fractures Risk Prevention Guidelines (Appendix 5) for consideration when completing an individual falls support plan

1. Post Falls Procedure

What you do at the time of a fall is really important. Safe moving and handling and prompt, appropriate care and attention can greatly improve an individual’s chance of making a full recovery. The immediate care of an individual, following a fall, should include safety at the scene and addressing any injuries sustained. An inappropriate response can delay the diagnosis and treatment of serious injuries.

* + **Residential Care Homes** – refer to Post Falls Flowchart (Appendix 2)
  + **Nursing Homes** – refer to Post Falls Flowchart (Appendix 3)
  1. Follow the first aid process, Head Injury, Assessment and Monitoring [CP017] and Medical Emergency Procedure [CP031]. A suitably trained member of staff must carry out head to toe checks for signs of injury at the same time as arranging for assistance.

Post Fall - Signs or suspected signs of injury

* + 1. If there are signs of injury or any uncertainty, colleagues must -
  1. Not move the person.
  2. Dial 999 (not 111) for people who have a suspected or obvious injury requiring urgent medical assessment or treatment.
  3. Administer First Aid. Colleagues must keep the person warm and as comfortable as possible (pillow, blanket and so on).
  4. Until the emergency services arrive, start post falls monitoring (HP118c) and continue post falls monitoring for 72 hours if the person is not in hospital. The purpose of the Post Falls Monitoring Record is to observe for signs of injury and to record these observations.
  5. Not give the person anything to eat or drink.
  6. Where there are visible signs of injury – such as deformity or discoloration of skin – complete a Skin Inspection Chart [HP111b].
  7. Prepare transfer documents and overnight bag (and any other information required locally)
     1. People with known osteoporosis, anticoagulant, antiplatelet or blood thinning medication are more likely to suffer injury as a result of a fall due to the increased risk of ‘hidden’ fractures or bleeding.
  + Residential colleagues must contact emergency services immediately (999)
  + Nursing colleagues must complete a physical assessment and clinical observations and contact emergency services (999)

If in any doubt, all colleagues must seek urgent medical assistance – 999 call.

Post Fall - No Signs of injury

* + 1. People with known osteoporosis, anticoagulant, antiplatelet or blood thinning medication are more likely to suffer injury as a result of a fall due to the increased risk of ‘hidden’ fractures or bleeding even if there are no obvious signs of injury.

**Residential colleagues must contact emergency services immediately**

**Nursing Homes complete clinical observations and then call 999**

* 1. inform the person’s GP as soon as possible.
  2. immediately start post falls monitoring - looking for pain, bruising, swelling, deformity of limbs, changes to mood / behaviour.
  3. complete the Post Fall Monitoring Record and
  + repeat after 30 minutes and then
  + every 2 hours up to 24 hours and
  + every 4 hours for another 48 hours - this provides a 72-hour monitoring
  + period
  + Head injury has monitoring time scales as defined in CP017.
  + A doctor may advise and request a variation to the monitoring timescales dependent on the individual, record any advice and action required
  1. Monitor, record, and action any changes to the person’s condition – **seek medical advice**.
  2. If reasonably sure of no hip fracture, return the person to bed / chair using appropriate moving and handling techniques and equipment.
  3. **Nursing only**: Record baseline observations (TPR, BP, oxygen saturations, level of consciousness). Record head injury observations[CP017] if the person has banged their head or had an unwitnessed fall.
  4. **In residential care,** colleagues must seek advice from the Community Nurse, GP, or Emergency Services.

Other Actions Required

* 1. Contact the person’s family / representative.
  2. Make safe any obvious environmental hazard that contributed to the fall.
  3. Review the person’s Falls Risk Assessment and associated Falls Support Plan – re-write if necessary
  4. Involve the person and their family or representative in any actions planned to reduce the risk of further falls.
  5. If required, refer the person to other specialist services (for example NHS Falls Teams if a service of this kind exists in the area).

Reporting

All Falls MUST be reported on RADAR even if no physical harm is suspected or reported. RADAR reports provide essential information and incident analysis which is reviewed within MHA’s governance procedures.

In addition to RADAR reporting colleagues must complete the following:

* 1. Individual Falls Diary [HP118e] to monitor patterns of falls such as times of day
  2. If required, notify the Regulator, and / or Safeguarding Team.
  3. If the fall was due to, or in connection with, a work activity (such as a failing in care, faulty equipment, or an environmental hazard) and where a fall results in a hospital visit and treatment for an injury colleagues must refer to the Health and Safety Team for review and potential RIDDOR reporting
  4. If there is a serious injury, death, or concerns about how a fall happened, the manager must carry out a root cause analysis investigation with support from MHA’s safeguarding lead.
  5. Falls from unrestricted windows are classed as a ‘Never Event’ and the manager must investigate and report in accordance with MHA’s Incident Response and Escalation Policy

1. Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| **Quality Governance Group (including H&S)** | * Maintain and monitor MHA’s internal Governance process * Review system reports identifying organisational risks * Analyse identified risk areas, trends, and patterns * Monitor actions with regard to non-compliance * Agree allocation of resources, as applicable to address any concerns or issues |
| **Area Managers** | * Responsible for monitoring falls incidents during prescribed audits and visits * Analyse identified risk areas, trends, and patterns * Act on, and report, poor performance and non-compliance * Review concerns with Managers to identify trends, patterns and any action required to manage risks * Disseminate any policy or procedural changes to respective teams * Monitor external reporting i.e., Safeguarding/Adult protection and regulatory bodies |
| **Home Managers and Scheme Managers** | * Responsible for promoting a culture of excellence in falls prevention and management * Responsible for ensuring all team members involved are aware of this policy and have the required knowledge and skills to deliver the standards expected * Ensure improvements are made where any concerns are identified through audits, monitoring, complaints, and investigations. * Support plan reviews and audits are completed in accordance with MHA’s internal auditing schedules * Support team members to attend relevant training * Provide support and ongoing leadership to promote good practice in the prevention and management of falls * Engage with external professionals, communicating any recommendations to the relevant care teams * Support teams to attend relevant training * Ensure colleagues attend first aid training, risk assessment and support planning training, as required for the role and responsibilities * Report all incidents on RADAR * Submit regulatory notifications as required i.e., safeguarding   Report outcomes of any investigation within Duty of Candour code of practice |
| **Quality Improvement Managers**  **Clinical Support Team** | * Work with operational colleagues to promote and deliver best practice * Provide support for services as requested * Report progress and concerns accordingly |
| **Nurses and Care Teams** | * Remain accountable and responsible for all aspects of their practice, providing a high standard of care and support * Evidence of regular updating and competency in all aspects of falls prevention and management * Make appropriate and timely referrals to external clinical professionals * Make sure that an individual’s specific needs are documented and communicated to colleagues, * Promote effective and documented communication of individual needs with relevant managers, and care teams * Comply with all aspects of this policy and procedural guidance * Complete all records as described within this policy and procedures, reviewing risk assessments and support plans monthly   Highlight any difficulties in understanding and implementing the process and any training requirements |

1. Training and Monitoring
   1. All MHA colleagues involved in supporting individuals with assessed needs in relating to falls to read, understand, and comply with this policy and associated procedures
   2. Managers must arrange for colleagues to complete falls training during their induction and every three years thereafter. Training must be tailored to the type of MHA Service that is being delivered.
   3. Residential services - basic first aid techniques, post falls monitoring and an emphasis on calling for professional help or emergency services will form the basis of training.
   4. Where the service is registered to provide nursing care, nursing staff must be trained to understand and assess -
   * **A**irway (A), **B**reathing (B), **C**irculation (C),
   * **AVPU** (rapid assessment of consciousness) – **A**lert or responds to **V**ocal stimuli, responds to **P**ainful stimuli, **U**nresponsive to all stimuli
   * **NEWS** (National Early Warning System)
   * **GCS** (Glasgow Coma Scale)

* 1. Moving and Assisting training should include the identification of possible practical scenarios that might relate to the risk of falls – for example, what to do if a person trips or falls whilst being assisted to walk.
  2. Falls related assessments, support plans and required actions are monitored in accordance with MHA’s internal audit schedules and governance process.
  3. RADAR reportable falls Incidents are monitored and escalated through the systems dashboard with key responsibilities dependent on role.

1. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Each colleague’s line manager must ensure that all teams are aware of their roles and responsibilities.
   3. This policy will be available to the people we support and their representatives in alternate formats, as required.
   4. Any review of this policy will include consultation with our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.
   5. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)
2. Impact Assessments (Inc. EDI)
   1. Equality, Diversity, and Impact Assessment to be confirmed.
3. Resources
   1. MHA related policy documents and guidance
   * Falls Preadmission Questionnaire
   * Multifactorial Falls Risk Assessment
   * Post Fall Monitoring
   * Equipment Check Record
   * Falls Diary
   * Head Injury – Assessment and Monitoring
   * Incident Response and Escalation Policy
   * Safeguarding Policy
   * Duty of Candour
   1. External References, Resources, and Guidance used to develop this policy document
   * Falls in Older People: assessing risk and prevention; 2013 (NICE) <https://www.nice.org.uk/guidance/cg161>
   * Slips and Trips in Health and Social care, Health and Safety Executive (HSE)

<http://www.hse.gov.uk/healthservices/slips/index.htm>

* + Regulation 12: Safe Care and Treatment; 2023, Care Quality Commission (CQC)

<https://www.cqc.org.uk/guidance-providers/regulations/regulation-12-safe-care-treatment>

* + Orthostatic Hypotension due to autonomic dysfunction: midodrine; 2015 (NICE)

<https://www.nice.org.uk/advice/esnm61/chapter/full-evidence-summary>

* + Measurement of lying and standing blood pressure: a brief guide for clinical staff; 2017, Royal College of Physicians

<https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff>

* + Falls within care homes; Care Inspectorate (Wales) <https://www.careinspectorate.wales/falls-within-care-homes>
  + RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013; Health and Safety Executive (HSE)

<https://www.hse.gov.uk/riddor/>

1. Appendices
   * Appendix 1: Falls Process Overview
   * Appendix 2: Residential Post Falls Flowchart
   * Appendix 3: Nursing Post falls Flowchart
   * Appendix 4: Falls reporting Guidance
   * Appendix 5: Falls and Fractures prevention Guidance
2. Version Control

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Version Date | Revision Description / Summary of Changes | Author | Next Review Date |
| 5 | November 2023 | Policy and associated documents reviewed, rewritten, and formatted.  References and best practice guidance updated | Head of Standards & Policy  Review Panel | November 2025 |
| 6 | January 2024 | Section 5 - Updated to include contacting emergency services when an individual is prescribed anticoagulant, antiplatelets or blood thinners  Appendix 2 – Residential and nursing flowchart updated to reflect procedural change  Reviewed with Clinical nurse and Senior Nurse Advisor and Quality Improvement Forum | Clinical Nurse Advisors  Regional Director  Head of Standards & Policy | November 2025 |
| 7 | June 2024 | Amended to reference the new Incident Response and Escalation Policy | Head of Standards & Policy | November 2025 |

# Appendix 1 – Falls Process Overview



# Appendix 2 – Residential Post Falls Flowchart



# Appendix 3 – Nursing Post Falls Flowchart

# Appendix 4 – Falls Reporting Guidance

Colleagues must review each fall to see if appropriate risk control measures were in place and if there is any learning that might prevent a fall of a similar nature happening again. For people sustaining an injury requiring admission to hospital, colleagues must consider the factors identified below. This is not a full list – colleagues must review each fall individually considering all risk factors

|  |  |  |
| --- | --- | --- |
| Examples of information | | Notes about collecting this information |
| **Reporting Factors** | Witnessed / not witnessed | Make a clear distinction between what was seen or heard, and the person’s account of what happened. |
| Outcome of investigations  recorded | When people are reported as having x-rays or other investigations after a fall, the results of the x-ray or other investigation must be included in the falls report. |
| Type of injury | Must be specific – such as, ‘fractured tibia’ not ‘broken leg’. |
| **Environmental**  **Factors** | Buzzer / bell available and within reach before fall | State whether there is an issue about being able to reach or use call bells. |
| If a fall from bed, whether bedrails were in use | Help assess how bedrail use is affecting falls or injury |
| Floor wet / dry / talcum  powder | Identify cleaning regime and whether floor was nonslip |
| Footwear | If problems with not wearing or unsuitable  footwear was this discussed (& documented) with person / representative? Was there a risk assessment in place? |
| Walking aid in use / in reach | Were they at bedside or in easy reach? May be storage / placement issues. |
| Layout of the room | Identify if there were any trip hazards / clutter |
| **Individual factors** | Mental state | Identify if the person was vulnerable to falls because of sedation, dementia or confusion due to infection for example. |
| First fall since moving in or repeat fall | Identify what was in place to prevent an initial fall or if something needs to change. |
| Days since moving in and moved in within the last month | To ensure timescales for assessment and preventing falls are tailored to when falls are most likely to occur. |
| Medication affecting risk  of falls | Sedative and psychotropic medication, or medication with drowsiness as a side effect, may contribute to falls. |
| What the person was doing at the time of the fall | Thinking about how the activity that was taking place immediately prior to the fall contributed to the fall. |

# Appendix 5 – Falls and Fractures Prevention Guidance

| Area | Concern | Considerations |
| --- | --- | --- |
| Mobility and Balance | Is the individual unsteady? Do they:   * Have muscle weakness; or * a fear of falling? | Referral to physiotherapist or another relevant external professional  Supervision plan – frequency  Encourage appropriate physical activity  Walking Aid  Moving and Assisting Assessment  Support to build confidence |
| Confusion or Cognitive Impairment | Does the individual have dementia or any confusion? | Health Needs – pain, dehydration, constipation, moods and emotions, infection  Medication side effects  Advice from CPN or GP  Promote exercise and activity, assistive technology  Environment |
| Falls History | Has the cause been identified, and previous falls discussed? | Preadmission falls questionnaire information and previous strategies  Review incidents, location, time, and reason  Investigate patterns, change of frequency and/or cause of falls |
| Medication | Is the individual taking any high-risk medication for example psychoactive or 4 or more different medications  Refer to medication risk assessments | Blood pressure checks (nursing) lying or standing  GP or CPN medication reviews  Observe for symptoms of dizziness, sleepiness, hallucinations |
| Continence | Is the individual incontinent of urine or faeces?  Any changes to normal continence habits? | Continence support – using the toilet and steps required to access toilets and bathrooms  Urine infection  Referral to continence advisor  Use of night lights, appropriate nightwear, and footwear  Provide a commode or urinal, where appropriate |
| Foot Health and Foot wear | Is footwear suitable for the individual?  Are there any problems with their feet? | Good footcare regimes, include in support plans  Referral to podiatry  Liaise with individual and their relatives regarding suitable footwear to reduce risks  Any loss of sensation in their feet |

|  |  |  |
| --- | --- | --- |
| Area | Concern | Considerations |
| Dizziness or Fainting | Does the individual appear to have dizzy spells or attacks of fainting? | GP review  Update all relevant support plans  Lying/standing blood pressure (nursing)  Refer to falls clinic |
| Environment | Is the environment safe, free of clutter and suitable for the individual? | Orientation to the environment to include all shared and outside areas  Assessment of the environment  Provide suitable aids, appliances, and signage  Referral to occupational therapy |
| Poor Nutrition | Is the individual underweight or has poor nutritional intake? | Referral to dietician & GP for any additional vitamin requirements  Complete MUST screening  Fortify meals and increase option for snacks  Referral to SALT if any swallowing issues or concerns are reported  Encourage fluid intake  Monitor and record food and fluid intake  Update all relevant support plans  Complete oral health assessment  Refer to dentist |
| Health | Is there a diagnosis of Osteoporosis or have any additional health risk factors? | Discuss bone health with GP – calcium  Medication review  Exposure to sunlight and lifestyle advice i.e., smoking and alcohol |