

# Reviewing patterns and trends of falls

Providers must analyse trends at an organisational level, as well as at an individual level, so that we avoid unnecessary hospital admissions and/or safeguarding reports. As a result, we can identify risks and patterns and address the underlying causes of problems before they escalate, or before poor practice goes unnoticed.

Please see below areas to ensure you are monitoring to prevent falls or illness, monthly.

To identify patterns and to put appropriate action plans in place, both from an individual, as well as from an organisational perspective. These must be documented in the care plans, and we review these regularly to establish trends and to prevent future incidents from occurring.

Use the Prevention and Enablement Framework to support you to ensure you are embedding Prevention and Enablement within your service, it will also allow you to see any gaps you may need to place within your action plans.

Please see the Appendix at the bottom of the document for links to all resources and supporting information.

Area	Organisational analysis	Individual analysis
Number of falls	Track numbers of falls to identify risk patterns and trigger preventative strategies that may be a pattern throughout the organisation.  <b>Audit Tool:</b> <ul style="list-style-type: none"> <li>• <b>Your digital/local Falls Data Analysis</b></li> </ul>	Ensure a Comprehensive Multifactorial Falls Risk Assessment is in place and updated monthly or post-fall. Ensure all actions taken to address each identified risks are implemented, documented, handed over to all relevant parties as appropriate, and monitored to ensure effectiveness.  Track trends for each individual  <b>Assessment Tool:</b> <ul style="list-style-type: none"> <li>• <b>Comprehensive MFRA. Make sure you cross-reference the HCPA one with your digital system care planning system</b></li> </ul>
Time of falls	Analyse any correlation with falls and staffing levels or handover periods. Assess	Evaluate medication timing and emotional state (e.g., boredom, isolation or timing of specific

	<p>medication timing and activity levels.</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Audit of Falls Severity Incident Report</u></b></li> <li>• <b>Or: Audit of your digital system falls analysis data /incident reporting system</b></li> </ul>	<p>medications, such as those for Parkinson’s Disease) around falls incidents.</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Falls Severity Incident Report</u></b></li> <li>• <b>Or: Your digital system falls analysis data /incident reporting system</b></li> </ul>
<p>Location of falls</p>	<p>Identify where falls are occurring (e.g., in bedrooms or communal areas) and review staffing levels and routines in these areas.</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Audit of Falls Severity Incident Report</u></b></li> <li>• <b>Or: Audit of your digital system falls analysis data /incident reporting system.</b></li> </ul>	<p>Use location of falls data to motivate individuals and to implement strategies to address mental wellbeing, especially if the individual is isolated in their bedroom. Does the individual’s environment need changing to suit their needs?</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Falls Severity Incident Report</u></b></li> <li>• <b>Or: Your digital system falls analysis data /incident reporting system.</b></li> </ul>
<p>Severity (grading) of falls</p>	<p>Monitor severity of all falls so there is an understanding of how often individuals are sustaining severe injuries (e.g. there may be organisational changes needed such as an increased focus on exercise, vitamin D supplementation, or nutrition to reduce risk of fractures, (if there is a pattern of fractures across individuals).</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Audit of Falls Severity Incident Report</u></b></li> <li>• <b>Or: Audit of your digital system falls</b></li> </ul>	<p>Identify and address individual risk factors and support bone health and reduce the risk of frailty/dependency.</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>Falls Severity Incident Report</u></b></li> <li>• <b>Or: Your digital system falls analysis data /incident reporting system</b></li> </ul>

	<b>analysis data /incident reporting system</b>	
Pressure sores	<p>How many people have pressure sores? Does there need to be a focus on movement, including nutrition to support recovery, especially if individuals have been in bed. Does the organisation have the appropriate pressure relieving equipment and documentation in place?</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of your pressure sore data</b></li> <li>• <b>Audit use of <u>Bed Care Prevention Tool</u></b></li> </ul>	<p>Plan mobility practice and exercises to improve strength. and review strategies to optimise nutrition, to support pressure sore healing and reduce frailty post-pressure sore. Use an appropriate pressure sore risk assessment tool to measure and review risk levels and address any risks identified appropriately</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Purpose T (NB. This tool <u>replaces the Waterlow/Norton Risk Assessment/Braden Scale, as these are very old and are no longer considered adequate</u>)</b></li> </ul>
Malnutrition and Dehydration	<p>Audit MUST scores and focus on weight gain and hydration through engaging activities throughout the organisation.</p> <p>Address staff training gaps</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of MUST score data, and calculation of MUST score.</b></li> <li>• <b>Audit of evidence of encouraging optimal food intake and hydration</b></li> <li>• <b>Training Matrix</b></li> <li>• <b>Audit number of Dietician/ SLT referrals and outcomes</b></li> </ul>	<p>Refer to dietitian where there is a concern about nutritional intake, address potential pain during eating/drinking, and encourage hydration. Can the person be more involved in their eating and drinking?</p> <p>Refer to SLT early for any problems with swallow, and for any increased frequency of chest infections/aspiration pneumonia</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><u>MUST score</u></b></li> <li>• <b>Choking/swallow risk assessments</b></li> <li>• <b>Numbers of chest infections/hospital admissions for the individual</b></li> </ul>
Chest infections / other	<p>Prepare seasonal infection prevention plans, assess</p>	<p>Identify susceptibility to chest infections/ UTIs/ wound infections/ Group-A Streptococcus (GAS)</p>

<p>infections/ Acute deterioration</p>	<p>need for environmental hygiene improvements.</p> <p>Audit of taking monthly Baseline Health Observations</p> <p>Audit use of RESTORE2/NEWS2</p> <p>Audit numbers of chest infections/SLT referrals/hospital admissions</p> <p>Address staff training gaps</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of Baseline Health Observations</b></li> <li>• <b>Spot checks of IPC procedures</b></li> <li>• <b>Training Matrix</b></li> <li>• <b>Audit of use of <a href="#">NEWS 2</a> and <a href="#">RESTORE2</a></b></li> </ul>	<p>infections and Invasive Group-A (iGAS) Streptococcus infections</p> <p>Promote good hygiene and increase fluid intake to reduce risk of infection.</p> <p>Identify early signs of acute deterioration: Take baseline measurements of Basic Health Observations (Respiratory Rate, Heart Rate, Oxygen Saturations, Blood Pressure and Temperature) on a monthly basis, as well as when a person shows signs of being unwell or demonstrates any other changes in presentation, so that you can escalate appropriately or prevent an unnecessary hospital admission. Use the RESTORE2 and NEWS2 documentation to determine when to escalate.</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><a href="#">NEWS 2</a> and <a href="#">RESTORE2</a></b></li> </ul>
<p>Bed prevention</p>	<p>Track numbers of people cared for in bed and ensure care plans show evidence of the strategies you have used to encourage people out of bed.</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of numbers of people cared for in bed</b></li> <li>• <b>Audit use of <a href="#">Bed Care Prevention Tool</a></b></li> </ul>	<p>Regularly update care plans to evidence how the person has been enabled to be out of bed, or where this has not been possible, to show that the person does still want/need to be in bed. How do you still ensure good quality of life?</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <b><a href="#">Bed Care Prevention Tool</a></b></li> </ul>
<p>Monthly GP call outs, hospital visits...</p>	<p>Monitor health trends and referrals to, and discussions with, external healthcare professionals.</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of numbers of 999 calls/Calls to</b></li> </ul>	<p>Ensure appropriate MDT involvement for the individual.</p> <p>Ensure actions agreed are followed up and implemented. Ensure outcomes are documented and appropriate actions are</p>

	<p><b>Avoidance of Admissions Services/Hospital admissions/GP call outs/ Referrals to external Health Professionals</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of sample of care plans</b></li> </ul>	<p>taken/referrals are made where needed.</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">NEWS 2</a></li> <li>• <a href="#">RESTORE2</a></li> <li>• <b>PLUS: Whatever is appropriate to the individual to monitor the health outcomes that are currently relevant to them</b></li> </ul>
Mental wellbeing	<p>Risk of depression or anxiety is identified using PHQ-2 and GAD 2, and people are referred for assessment where appropriate Planning for winter, clocks changing and monitoring mood changes.</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit of numbers of people with Anxiety /depression.</b></li> <li>• <b>Audit of numbers of referrals to Mental Health Teams.</b></li> <li>• <b>Audit of use <a href="#">PHQ 2</a> and <a href="#">GAD 2</a></b></li> <li>• <b>Audit of sample of care plans</b></li> </ul>	<p>Improvements are monitored as well as deterioration: Examples may include, spending more time in their room, not engaged with activities or conversations, feeling low and isolated. Some individuals may also struggle when moving into care from their own home, ensuring there is time taken to get to know them, making them feel safe and comfortable, they have a goal to achieve.</p> <p><b>Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">PHQ-2 and GAD-2</a> Screening</li> </ul>
Moving and Assisting Care Plans and Risk Assessments	<p>Audit these to make sure they are in place for each person and carry out spot checks to ensure they are being followed Audit Equipment</p> <p><b>Audit Tool:</b></p> <ul style="list-style-type: none"> <li>• <b>Equipment audits</b></li> <li>• <b>Loler inspections</b></li> <li>• <b>Audit of sample of care plans</b></li> </ul>	<p>Ensure a detailed Moving and Assisting Risk Assessment and Risk Positive Management Plan is in place for each person. Ensure this is correlated and triangulated with other areas and with any external health professional's recommendations. Ensure it is updated when there are any changes. Ensure that the changes are handed over and monitored to ensure they continue to be appropriate.</p>

		<b>Assessment Tool:</b> <ul style="list-style-type: none"> <li>• <b>Moving and Assisting Risk Assessment and Risk Positive Management Plan</b></li> <li>• <b>Care Plan Reviews</b></li> </ul>
--	--	---

## Appendix

- The Prevention and Enablement Self-Assessment Framework:
  - Prevention in social care is about encouraging people to be proactive about their health and wellbeing. It can increase independence and significantly reduce or delay the need for care and support services.
  - Meeting the standards that are set out in the [HCPA Prevention and Enablement Self-Assessment Framework](#), can help your organisation meet these responsibilities. [Click here to download](#)
- [Comprehensive Multifactorial Risk Assessment](#)
  - Use this against your own risk assessments and add any other risks that may not be documented. Use the Risk Management strategies to ensure person centred interventions are documented within a persons care plan.
- **[NEWS 2](#) and [RESTORE2](#)**
  - RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment.
- [Management of somebody falling in a Care home](#): This pathway includes the below documents:
  - [Management of Person who has Fallen in Care Home Pathway Checklist for Red and Amber Flags](#)
  - [Post falls Monitoring and Falls Severity Incident report](#)
- [MUST Score](#) – Malnutrition Universal Screening Tool
- [Bed Care Prevention Tool](#)
  - This tool is designed to guide residential and nursing home staff when deciding if a person should or should continue to be cared for in bed.
- [PHQ 2](#) and [GAD 2](#)
  - Risk of Anxiety and Depression Screening Tool.