Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Falls Prevention training

Falls Prevention training

Aim

By the end of this session you will be able to:

- Understanding the impact of falls.
- Identify environment risk factors and create a safer environment for inpatients.
- Describe the importance of a multifactorial risk assessment.
- Describe how to reduce the risk of falls.
- Understand the initial management of patients post-fall.

Introduction

Falls in hospital are the most commonly reported patient safety incidents, more than 240,000 are reported in acute hospitals & mental health trusts in England & Wales every year, (National Audit of inpatient Falls 2015). The cost of treating falls in hospitals in the UK has been estimated at between £15 Million and £87 Million each year.

Inpatients are at increased risk of falling, risk factors of this include:

- Older patients
- Patients with long-term conditions and disabilities
- Patients with acute illness
- Patients with comorbidities
- Patients who have had an operation that has affected their mobility
- Patients affected by alcohol

Admission to hospital will put these vulnerable patients at an even greater risk of falling. This is due to the unfamiliar environment and side-effects of investigations, medications and treatment.

Research has shown that multiple interventions performed by the multidisciplinary team and tailored to the individual patient can reduce falls by **20-30 %.**

Key Points

- Falls in older people are common
- A fall may be due to an acute illness
- A fall may be a one-off event (an accident)
- Recurrent falls are never accidental (‘mechanical’) – they are caused by medical problems, many of which can be treated.

- In most cases, there is more than one reason why an older person is falling (multi-factorial).
- Unexplained falls could be due to syncope (fainting caused by a temporary reduction in blood flow to the brain).
- Falls can be caused by dizziness which requires further evaluation.
- A multi-factorial assessment is a focused clinical history and examination which looks for the several different reasons why an older person is falling.

Consequences of a fall can be devastating and life changing.
These can include -

Physical

- Discomfort and pain – pain can be caused by skeletal or soft tissue damage.
- Serious injury– a fracture of the femur is most common but fractures on other sites may occur (e.g. vertebrae or forearm).
- Inability to look after oneself/ Long-term disability
- Hypothermia
- Pressure-related injuries and infection, (these can occur if an elderly patient has a long lie after a fall).
- Death

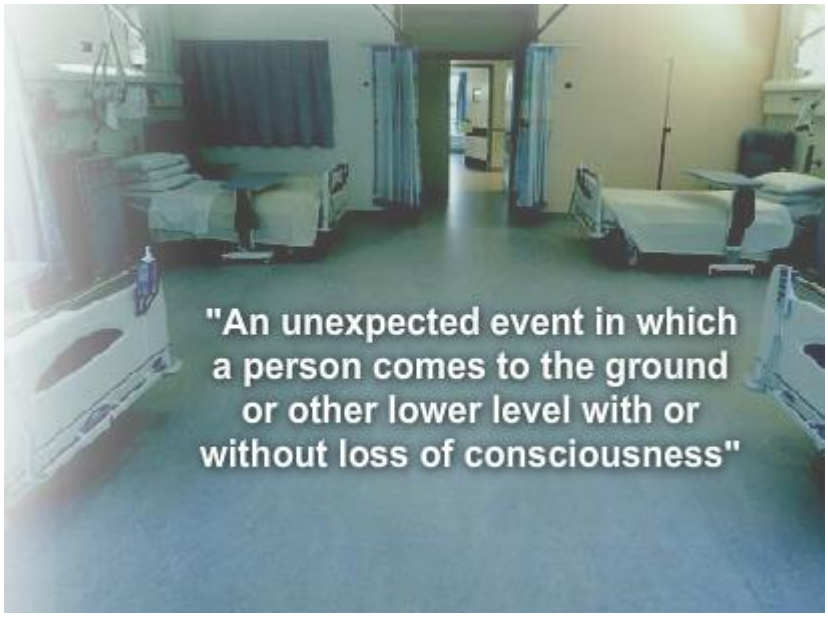
Psychological

- Loss of confidence
- Fear of falling - self-imposed restriction on mobility, which leads to decreased independence and can contribute to future falls resulting in more serious injuries. This can also be linked with depression and social isolation.
- Loss of independence
- Distress and embarrassment

Social

- Loss of independence - decreased mobility and ability to carry out activities of daily living. This can result in an increased package of care or admission to residential / nursing home accommodation.
- Loss of social contacts
- Financial cost of help/care.
- Changes to daily routine.
- Decreased quality of life.

Definition of a fall



A fall can include all types of incident such as -

- Slips
- Trips
- Falls
- Faints

Slip

A slip is to slide accidentally causing the person to lose their balance; this is either corrected or causes a person to fall.

Trip

A trip is to stumble accidentally often over an obstacle causing the person to lose their balance, this is either corrected or causes a person to fall.

Types of falls

- **Accidental Fall – a f**all that occurs due to extrinsic environmental risk factors or hazards: spills on the floor, clutter, tubing/ cords on the floor, etc., or errors in judgment, such as not paying attention.
- **Anticipated Physiological Fall - f**actors that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur to the patient's existing physiological status, history of falls, and decreased mobility upon assessment.

- **Unanticipated Physiological Fall -** factors associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk scale: unexpected orthostatic; extreme hypoglycaemia; stroke; heart attack; seizure.
- **Behavioural (Intentional) Fall -** patient who has behavioural issues and voluntarily positions his/her body from a higher level to a lower level.
- **Assisted Fall** occurs when the patient begins to fall, is assisted by another person, but nevertheless reaches the ground or other unintended surface

Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

There are many risk factors that can contribute to an older person falling. These risk factors can be divided into three categories, Intrinsic, Extrinsic or Behavioural.

Intrinsic

- Age, higher risk of injury in older females
- Fear of falling/previous history of falls.
- Deterioration in health, mobility, and strength
- Reduced mobility/poor transfer/poor gait or balance
- Medical conditions e.g. dizziness, vertigo, syncope, hypotension, incontinence, Epilepsy, Parkinson disease, Stroke, Osteoporosis, Osteoarthritis.
- Confusion – dementia/ delirium, cognitive impairment and depression
- Poor communication – lack of understanding of advice
- Alcohol misuse
- Polypharmacy (multiple medications), sleeping tablets, diuretics, hypnotics,
- Sensory deficit – sight/hearing/balance.
- Poor nutrition and diet
- Badly fitting footwear and clothing
- Female gender

Extrinsic

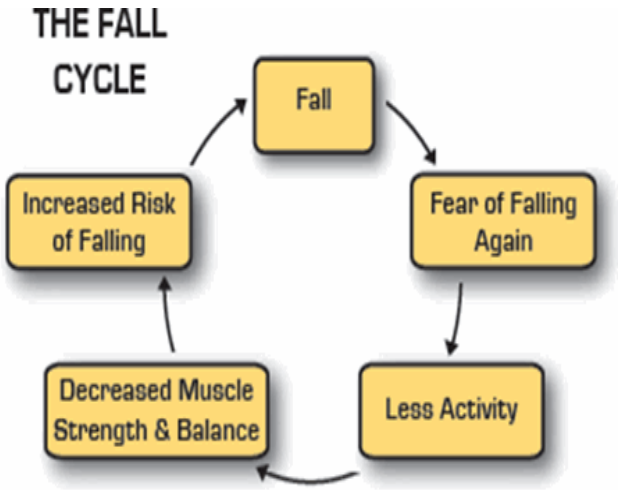
- Lines, tubing, IV stands, walking aids, trailing flexes and cables
- Uneven or slippery surfaces
- Loose mats or rugs
- Reduced observation/visibility e.g. side rooms/ darker at night time
- Inadequate light (especially on stairs)
- Poor steps and stairway design and repair
- Lack of hand rails
- Poor Bathroom design (lack of seating, call bells, position of sinks and toilet)
- Inappropriate height of chair and bed.
- Broken equipment

- Patient Flow – patients moved from bed to bed may become disorientated.
- Foot wear - non compliance
- Unfamiliar environment or cluttered environment

Behavioural

- Getting up in the middle of the night in the dark
- Rushing to bathroom or toilet.
- Standing to put on lower garments/dress
- Over stretching and over reaching.
- Non-compliance with advice
- Privacy & Dignity/Independence issues (eg. when the patient does not ask for help through embarrassment, or fails to ask for help to mobilise.

Falls history – has the patient fallen before? Has this affected their confidence to mobilise?



A multifactorial assessment should occur on admission and as the patient's condition or treatment changes.

Vision

Poor vision - age-related changes such as a reduction in visual acuity, depth perception, contrast sensitivity, and visual fields, and ocular impairments such as cataracts, macular degeneration and glaucoma can prevent the individual from noticing objects in the environment. In addition, residents who are adjusting to new glasses, or have impaired depth perception due to bifocals, are at increased risk of falls.

- Individuals with vision problems are more than twice as likely to fall as people without vision problems.
- Vision problems can affect balance, the ability to walk, and upper and lower body strength.

- Uncorrected visual loss can have a more subtle but equally detrimental effect on falls risk.
- Wearing bifocal and multi-focal lenses can increase the risk of falling.
- Patients wearing glasses with an outdated or wrong prescription (which is more common than you might think) are much more at risk of taking a tumble.
- Even a small reduction in depth perception can lead to trips over obstacles or overstepping on stairs.

Eye diseases (such as glaucoma, cataracts, macular degeneration, diabetic retinopathy) and normal age-related vision changes can cause:

- Blurry or distorted vision
- Sensitivity to bright lights/glare
- Difficulty seeing objects
- Problems seeing edges and changes in surfaces
- Difficulty seeing at night
- Problems judging depth and distances.

Cataract

Glaucoma

Diabetic retinopathy

Hemianopia

Effect of vision loss

- Difficulty maintaining balance
- Shuffling or problems walking
- Difficulty seeing clutter or obstacles
- Difficulty going up and down stairs, steps, and curbs
- Reduced activity, leading to decreased strength and balance

To help to reduce the risk of falls all patients should have a visual assessment.
Ask the patient -

- When did you last have a sight test? **(**should be every year**)**

- Do you wear glasses?
- Are your glasses up to date?
- What do you wear your glasses for? eg reading / distance / everything [bifocals/varifocals]?
- Have you got your glasses with you?
- Do you have any eye conditions? If so, are you using any prescribed treatment? (e.g. eye drops for glaucoma).

Actions

- **Document the answers in the Falls Flow sheet.**
- If the patient does not have their glasses, ask their carer to bring them in.
- Discuss with the patient and put in place immediate actions to prevent falls, e.g. wearing glasses, moving the call bell, walking aids, keep belongings near at hand.
- Think about the patient's position in the ward, can they see staff if they need help? (Lighting levels, bed/chair orientation)?
- Document your concerns and immediate actions in the **Falls Flow sheet**.
- Speak to the medical team/Advanced Nurse practitioner (ANP) if you are concerned about any of the vision checks.

Hearing

Older people with hearing problems that may affect balance and concentration are more likely to fall.

Vertigo

- Vertigo is most commonly caused by a problem with the balancing mechanism in the inner ear. There are several reasons why this happens, but the most common is infection. It results in a sensation of spinning, even when someone is standing completely still.
- **Treatment** will depend on the cause of problem, and may consist of antibiotics for the infection and antiemetics (anti sickness tablets) for the nausea.

Impaired touch

- A reduction in the ability to sense contact with surfaces beneath the feet is a normal age-associated change.

Impaired proprioception

- Incorrect or delayed feedback from the sensory system that provides an awareness of limb and body position can impair the balance maintenance or recovery systems.

Neurological problems

There may be neurological disease causing motor and sensory impairment and increased risk of falls. For example:

- Even minor strokes can cause significant weakness.
- Parkinson's disease impairs mobility (abnormal postures, freezing of gait, frontal impairment, poor leaning balance and leg weakness are independent risk factors).
- Neuropathy may occur with, for example, diabetes.
- Proximal myopathy (from, for example, thyrotoxicosis, Cushing's syndrome and use of steroids) may impair mobility, particularly rising from sitting.
- Conditions that impair co-ordination will impair mobility and predispose to falls.
- Cognitive impairment may impair co-ordination. This may not be immediately apparent but the patient may have early and concealed dementia predisposing to falls. The recognition of dementia can be difficult; however, cognitive screening tests such as the Six-item Cognitive Impairment Test can help.

Poor nutrition or hydration:

- Generalized weakness, fatigue, and electrolyte imbalances can increase the risk of falling, and even trigger a delirium.
- Dehydration leads to balance issues linked to falls and fractures.

Cardiovascular

Cardiovascular disorders are increasingly recognised as risk factors for falls. This clearly affects many of our inpatients at LHCH.

Most commonly-

- Vasovagal syncope (fainting caused by a temporary reduction in blood flow to the brain).
- Postural (orthostatic) hypotension
- Arrhythmias

Therefore, assess if the patient has a medical condition that makes them prone to slips, trips and falls, (e.g. cardiovascular problems may cause dizziness or a drop in blood pressure when moving from rest to a standing position). Encourage oral hydration, use of IV fluids or stopping BP medication until it resolves.

Postural Hypotension

Postural hypotension is a drop in someone’s blood pressure when they assume an upright position. This can occur when going from lying to sitting or from sitting to standing.

Symptoms of postural hypotension include-

- Dizziness
- Faintness
- Light-headedness
- Weakness
- Changes in vision such as blurring or blacking vision

- Losing consciousness with or without warning – this is known as a black out or a faint
- If someone is complaining of dizziness upon standing, their blood pressure should be checked both when lying down and when standing.

Risk reduction

- Refer for a medication review- patients who are on four or more medicines, are at greater risk of having a fall.
- Give advice about medication - many older people commence night sedation or request stronger sedation because they feel they are not sleeping enough at night. It is important to highlight that, as we get older our sleeping patterns change and we may require less sleep. Try to avoid sedation and provide a calm environment and offer a light snack and warm milk at bed time.
- Patients should be advised to take diuretics (water tablets) in the morning, to prevent having to get up at night to go to the toilet.
- Be aware of increase risk of falls following administering pre-medication.

Continence

A large number of our elderly population will have abnormal urinary function like incontinence, urgency and frequency, which can contribute to the risk of a fall.

Incontinence is a term that describes any accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence).

Incontinence is a widespread condition that ranges in severity from 'just a small leak' to complete loss of bladder or bowel control.

Frequent bladder difficulties -

- Urgency of passing water
- Frequency of passing water
- Urinary Tract Infection (UTI)
- Taking diuretics (Water tablets)
- Incontinence

Risk Factors

- Slipping on wet surfaces
- Increased speed when walking to the toilet
- Nocturia (waking at night to void) can result in poor sleep, which is associated with increased falls risk.
- Getting up to the toilet in the dark during the night.
- Reduced dexterity, such as arthritis or stroke causing difficulty in manipulating undergarments, etc.
- Need to use a walking aid - urinary incontinence is a significant risk factor for those who can't stand without support.

- Reduced mobility and balance - impaired ambulation and balance make it difficult to reach the toilet and thereby increase the risk of falls.
- Need for toileting assistance and impaired cognition (in other words, performing a secondary task, such as walking and concentrating on getting to the toilet, may be difficult).
- Urinary frequency and toileting - the combination of urinary frequency and the need for frequent assistance with toileting is much more of a fall risk factor than incontinence by itself.

Strategies for reducing falls risk

Patients may have more than one type of urinary incontinence. The goal of treating urinary incontinence is to improve the continence status of the patient by modifying those factors causing incontinence.

- Determine frequency and type of incontinence (i.e. if Urge, Stress, Overflow, Functional or Mixed cause incontinence) - ask the patient about their normal bladder /bowel patterns and record in Flow sheets.
- Exclude UTI or constipation
- WTU - if positive – MSU and inform doctor of positive result.
- Treatment for faecal impaction.
- Implement a toilet assistance programme that best matches the patient's needs and pattern of voiding.
- Use of hourly rounding in falls prevention.
- Identify and treat the cause of incontinence, including medication side effects.
- Diuretics (water tablets) should be taken in the morning to prevent frequent visits to the toilet at night.
- Identify and address co-morbid falls risk factors (gait and balance, transfer ability, reduced dexterity, etc.) which can have an impact upon toileting.
- Ensure that patients with impaired mobility can reach/use the nurse call bell.
- Respond to toileting requests promptly, especially if the patient requires assistance to get to the toilet.
- Locate patient near to the toilet if possible. Consider a bedside commode or urinal if the toilet is not close by.
- Ascertain patients perspective of assistance required.
- Maintain patient privacy and dignity.
- Keep the pathway to the toilet obstacle free and leave a nightlight on in the bedroom/bathroom at night.
- Assess lighting and signage to toilet
- Ensure that patient is wearing suitable clothes that can be easily removed or undone by themself or staff and that the patient wears footwear to reduce slipping in urine.
- Ensure all continence products are available; provide pads or other continence aids.
- Provide patient information leaflets on how to manage continence.
- Improve quality and access to toilet facilities and improve mobility.
- Support with bladder training / timed voiding / prompt voiding for urge incontinence.

- Educate patients about pelvic floor exercises, particularly for patients with stress and urge incontinence and for men with post prostatectomy problems.
- Refer to medics, pharmacist, occupational therapist or tissue viability as appropriate for continence management assessment.
- Know your patient, ensure a detailed handover is given to the team.

Link Care rounds to falls prevention – (6P's)

1. **Pain -** ask patients you have any pain or do you have any discomfort anywhere?
2. **Position -** make sure the patient is comfortable and assess the risk of pressure ulcers.
3. **Personal needs -** schedule patient trips to the bathroom to avoid risk of falls, ask do you need help with the toilet? Do you need a drink?
4. **Pathway -** ensure the environment is clutter free.
5. **Possessions -** make sure the items a patient needs are within easy reach and ensure call bell in reach.
6. **Plan -** ensure the patient knows when you will come back again.

Dementia / Cognitive Impairment

Many people who have a cognitive impairment and/or dementia may experience the following, putting them at a higher risk of a fall.

- Difficulty in recognising environmental hazards
- Unaware of their own limitations and mobility
- Have a change in walking pattern and low blood pressure upon standing
- Many who require assistance to walk can often put themselves at risk by attempting to walk unaided.

Factors that may cause a person to mobilise unaided may include -

- Physical discomfort - pain, infection, constipation
- Dehydration
- Recent infection
- Need to exercise/move around
- Inadequate nutrition
- Stress
- Fatigue
- Communication - unable to express needs
- Memory - unable to retain information
- Disorientation – time and place
- Decreased judgement - can lack insight into capabilities
- Decreased sensation
- Light

- Temperature
- Sound
- Space
- Seating
- Loneliness
- Familiarity - need to seek out a familiar face/place
- Fear
- Frustration - not being able to complete a desired/ request task
- Lifelong habits
- Independence - need to be independent

Common risk factors for falls and delirium are:

- Increasing age
- Multi-morbidity
- Immobility
- Medication (sedatives and anti-cholinergics)
- Cognitive impairment
- Sensory impairment
- Dehydration / postural hypotension

Management of delirium and falls should overlap -

- Identify patients at risk before delirium develops by completing a Delirium Risk assessment document and add Delirium Risk Reduction parameters in the Assessment and Care Flowsheets.
- Try to reduce the chance of delirium developing in patients deemed at risk
- Identify delirium early when it develops.
- Try to rectify any reversible causes of delirium.
- Avoid using drugs unless the patient is a risk to themselves or others – **DRUGS DO NOT TREAT DELIRIUM**
- Utilise Enhanced levels of Care

Osteoporosis

Osteoporosis is a disease where the bones become very porous and fragile, with a higher risk of fracture. It is often referred to as the silent disease, as no symptoms are present until a bone is broken.

Osteoporosis risk factors -

- Elderly
- Female
- Untreated early menopause (<45)
- Low body weight (BMI <19)
- History of a low trauma fracture
- Certain medical conditions
- Family history
- Inactive

- Poor dietary calcium
- Vitamin D deficiency
- Smoker
- Excess alcohol
- Long term corticosteroid therapy

Prevention and treatment of Osteoporosis may include Calcium, Vitamin D, There are also groups of medication that can be prescribed for the treatment of osteoporosis. They increase bone density by decreasing the rate of absorption of old bone, and/or increasing the formation of new bone.

Lifestyle advice

Smoking

It is recommended that people stop smoking, as it -

- reduces the absorption of calcium
- reduces the activity of the cells that lay down new bone

Alcohol

It is recommended that people reduce their alcohol consumption, as excessive amounts-

- reduce the absorption of calcium
- may interact with medication
- increases susceptibility to falls
- alcohol consumption dulls neurological capacity, affecting balance and co-ordination, and consequently increases the risk of falls.

Exercise

Exercise can help to reduce the risk of developing osteoporosis. The exercise must be weight bearing, which puts pressure on bones helping them to strengthen. Examples of weight bearing exercises are -

- Walking
- Dancing
- Climbing stairs

Foot Care/Footwear

Some common problems are -

- Infection - this occurs where there has been a break in the skin. The area could be painful, swollen, hot, red, and a discharge may be present.
- Corns/callus- may be painful or discoloured
- Ingrown toe nails
- Thickened toe nails
- Dry skin with cracks around the heels
- Fungal infection of the skin e.g. “Athlete’s foot”

Helpful tips for staff assessing an individual’s risk of falling, include -

- Observation of a person's posture, i.e. their normal gait and stance. Is the person leaning to one side or forward?
- Watch how a walking stick or frame is used.
- Examine the feet while bathing, or during personal care.

Practical foot care

- Wash feet regularly with soap and warm water, especially between the toes
- Report any abnormal changes in colour, unusual swelling or breaks in the skin, or infections.
- Feet should be dried well, paying particular care between the toes. Use a cotton wool bud if toes are difficult to separate
- After drying the feet, apply a moisturiser (aqueous cream) especially around the heels.
- Cut nails straight across, not too short and not down the sides. Afterwards file them in one direction.

Footwear

Some footwear can increase the risk of slips, trips and falls by making people more prone to poor balance and bad gait, or by making it difficult to judge surface friction and distance from the floor. Examples of unsuitable footwear for the elderly include:

- Loose, worn or backless slippers. These are one of the most common causes of older people falling.
- Slip-on shoes, such as sling backs or flip flops which can slip and trip the patient up.
- Shoes with slippery or worn soles can cause the patient to slip, especially on wet floors or in wet weather.
- Shoes with a heel higher than one inch, or with a narrow heel, can make the foot unstable and can cause the ankle to turn.

The characteristics of a safe shoe area show with-

- A high back or collar to support the ankle.
- A hard, slip-resistant sole.
- A heel height lower than one inch.

It is also recommended that older people wear well-fitted, slip-resistant slippers in the ward area rather than walking barefoot or in socks or tights, or anti-embolic stockings.

Environment

Most often, it is a combination of factors that leads to a fall. Remember that patients at higher risk of falls must be cared for in an environment that minimises future falls. Environmental factors ranging from lighting levels to type of flooring are significant fall risk factors and can be relatively easily changed to create fall-prevention and injury-reduction design interventions.

To reduce the risk of falls assess the patient's environment, factors for consideration are-

- Is the bathroom/toilet clearly sign posted?
- Is lighting adequate both in the ward and in the bathroom?
- Is there somewhere in the bathroom for the patient to sit and dress after their shower/wash?
- Are there grab rails for them to hold on to?
- Can the patient see the nurse call bell in the bathroom?
- Is their pathway free of clutter?
- Is the bed as low as possible in case the patient falls out?
- Has a bed rail assessment been undertaken on a regular basis?
- Have they any lines, drains, catheter tubing, drip stand that puts them at risk?
- Can they get out of bed easily without chairs and lockers impeding them?

Also consider-

- Are slippers close at hand and are they safe footwear?
- Have walking aids been checked to ensure safe to use?
- Is a 'Call don't fall' sign within patient's view?
- Have care partners been advised of how they can support the patient?
- Has the patient received falls prevention information?

Bed rails

Bed rails are designed to reduce the risk of patients falling from height e.g. accidentally slipping, sliding, falling or rolling out of bed. Bed rails when used in this way are not classed as restraint.

Bed rails will not prevent a patient leaving their bed and falling elsewhere and should not be used for this purpose.

The use of bed rails is not appropriate for all patients. For patients who can mobilise without help from staff, bed rails would create a barrier to independence. They may create a greater risk of falling and injury for patients who are both confused and mobile enough to climb over them, or become entrapped in them.

Balancing the risks and benefits of bed rails for individual patients is a particular challenge as many of the factors which increase the likelihood of injury from bed rails, for example, being older, cognitively impaired and with poor mobility, also increases the likelihood of falls from bed and subsequent injury.

- Bedrails should not be used to restrict a patient who wants to get out of bed (even if the patient would be unsteady and at risk of falling once they were out of bed).
- Bedrails are safety devices used to reduce the risk of patients accidentally slipping, sliding or rolling out of bed.
- Patients decide, if they are well enough to understand when staff explain the risks and benefits.

- If patients are too ill to decide, the nurse responsible for their care needs to decide if bedrails are in the patient's best interests.
- Staff should discuss bedrails with relatives whenever possible, but relatives cannot take a decision for the patient.

Actions to be taken when a patient has fallen

Assess the patient's condition and safely transfer the patient to an appropriate environment, if it is safe to do so.

The medical staff must be contacted to review the patient immediately.

Consider the possibility of a fracture or the potential for spinal injury **before** the patient is moved. Consult with the medical staff if unsure.

Following a dynamic assessment, if the patient is able they will be encouraged to independently transfer, if this is not possible guidance/ minimum assistance will be offered from staff. If more than minimum assistance is required then one of the following is to be used, a hoist or the emergency lifting sheet (this is a high risk manoeuvre and requires 7 people to assist).

- The ward manager or out of hours the hospital coordinator must also be notified about the incident.
- If there is no obvious evidence of a fracture or suspected spinal injury safely transfer the patient back to their bed.
- If any fracture or potential spinal injury is suspected the patient must be transferred to a local Accident & Emergency Department by emergency ambulance.
- Record observations and document in EPR.
- Ensure the surrounding environment is safe and clutter free
- Ensure the fall is appropriately documented in EPR in assessment and care flow sheet, (add parameter and Falls record).
- Ensure the incident is reported on Datix.
- Undertake a repeat falls risk assessment and complete falls risk prevention flow sheet appropriately.
- If a head injury is suspected, commence neurological observation using the Glasgow Coma Scale (GCS). Any changes should trigger an urgent medical review.
- Ensure thorough handover
- Relatives should be informed, (with the patients consent) of slips, trips and falls and subsequent injuries as soon as possible.

Falls causing injury should be reported through Datix, following this a formal Root Cause Analysis (RCA) is undertaken and an action plan developed and shared with the wider team. Lessons learned are shared at ward level, through the Falls Group and through Divisional Governance.

Discharge Planning - referrals may be made to-

The GP

- **The GP must be informed of any fall during the patients stay.**
- GP's may also be able to advice on Strength and Balance training which can improve muscle strength and reduce the risk of falls.
- Many community centres and local gyms offer specialist training programmes for older people and can provide information on strength and balance exercises that can be performed at home.
- There's also evidence that taking part in regular tai chi sessions can reduce the risk of falls. Tai chi is a Chinese martial art that places particular emphasis on balance, co-ordination and movement.
- The patient can also request a home hazard assessment to identify potential hazards around the home that affects their risk of falling.
- Fitting a personal alarm may also be recommended so they can call for help in case of a falls.
- Further information can also be found on the GOV.UK website.

In addition consider referral to the following team-

Allied Health Professionals (Occupational Therapy, Physiotherapy, Exercise Physiologist) who can-

- Identify balance, mobility and strength problems and then tailor an individual exercise or activity programme.
- Supervise and assist people with delirium and dementia to ensure safe transfers and ambulation.
- Give education and information about footwear features that may reduce falls risk.
- Modify the resident's room to ensure safe mobility.
- Provide assistive devices and equipment and training in their safe use.
- Ensure safe and appropriate mobility aids/

Dietitians can-

- Assess fluid and nutrient intake and provide dietary and supplement recommendations for increasing calcium, Vitamin D intake, and fluids if required.

Podiatrists' can-

- Assess feet for pain, deformity, poor sensation
- Provide orthotics, recommendations for appropriate footwear

District nurses can - advise on local fall prevention and continence services.

Audiology Department can - advise on problems with NHS hearing aids.

Optician / Optometrist can provide a sight test, identify vision problems that can be addressed through new prescription glasses/ contact lenses and low vision therapies designed to help prevent falls.

Continence Advisory Service can offer advice and support in continence management.

Support, Advice and Information Contacts include-

- Help the Aged
- Age Concern
- RoSPA (Royal Society for the Prevention of Accidents)
- National Osteoporosis Society
- Alzheimer's Society