# Community Based Falls Prevention Resource Pack

**Reference Number:**

NHSCT/09/232

**Responsible Directorate:**

Primary & Community Care for Older Peoples’ Services

**Replaces (if appropriate):**

Northern Trust Community Based Falls Prevention Resource Pack (NHSCT/08/77)

**Policy Author/Team:**

- Cathy Patterson  
  Community Consultant Geriatrician/ 
- Fiona Morrow  
- Senior Occupational Therapist/ 
- Leesa Houston  
- Senior Health Promotion Officer/ 
- Daniel McCoy  
- Senior Podiatrist/ 
- Andrea Garner  
- Senior 1 Physiotherapist/ 
- Lisa Carolan  
- Senior 1 Physiotherapist/ 
- Sharon Love  
- Falls Injury Prevention Nurse

**Type of document:**

Trust Wide

**Approved by:**

Bronagh Scott  
Director of Primary & Community Care for Older Peoples’ Services

**Date Approved:**

23 October 2009

**Date Policy disseminated by the Policy Unit:**

8 January 2010

**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
A Community Based Falls Prevention Resource Pack

“Falls Prevention Is My Intention”
CONTENTS

- Introduction 3
- Consequences of a fall 4
- Definitions 5
- Falls Osteoporosis and Fracture Facts 6

Section One – Staff information
  1.1 Falls risk factors 8
  1.2 Fear of falling / History of falls 9
  1.3 Osteoporosis 10-13
  1.4 Medication 14-16
  1.5 Postural hypotension 17
  1.6 Alcohol 18
  1.7 Dementia / Cognitive Impairment 19
  1.8 Continence 20
  1.9 Exercise 21-22
  1.10 Eyesight 23-26
  1.11 Hearing 27-28
  1.12 Foot Care / Footwear 29
  1.13 Environment 30

Section Two – Risk Assessment
  2.1 Risk Assessment 32
  2.2 Falls Risk Assessment Tool (F.R.A.T) 33
  2.3 Falls Intervention Tool 34-35

Section Three – Falls Register
  3.1 Recording a fall 37
  3.2 Falls Register 38
  3.3 Falls Register Analysis 39

Section Four – Information leaflets
  4.1 Osteoporosis 41
  4.2 What should I do if I fall? 42
  4.3 Hip Protectors 43
  4.4 Pendant Alarms 44
  4.5 Bed and chair monitors 45
  4.6 Medication 46
  4.7 Exercise 47
  4.8 Making Your Home Safer 48-49
  4.9 Eyesight 50
  4.10 Footwear 51
  4.11 Foot Care 52

Section Five – References 54-57

For further advice/information please contact;
Sharon Love, Falls Injury Prevention Nurse
Tel: 028 9442 6234    E-mail: sharon.love@northerntrust.hscni.net

-2-
Introduction

This pack has been developed to support the following strategies / documents, which look at improving the health and well being of our elderly population.

- National Service Framework – Standard Six “Falls”
- National Institute for Clinical Excellence – “Falls, The assessment and prevention of falls in older people”
- Ringing the Changes
- Investing in Health
- DHSSPS Home Accident Prevention Strategy and Action Plan
- Living Well – Ageing Better

Objectives
To provide a falls prevention pack, that will

- Assist staff members with identifying actual and potential fallers
- Supply information on appropriate risk reduction measures

Aims
- Provide information regarding contributory risk factors in relation to older people falling
- Provide guidance on risk reduction measures
- Provide a falls prevention risk assessment tool
- Provide information on pathways for appropriate referrals to other services
- Provide a resource of information
Consequences of a fall

Consequences of a fall for an older person 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)
- Hypothermia, pressure-related injuries and infection—these can occur if an elderly patient has a long lie after a fall
- Inability to look after oneself
- Long-term disability
- Death

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

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
- Guilt
- Blame
- Anxiety
- Embarrassment

We must remember that,

FALLS NEED NOT ALWAYS BE
AN INEVITABLE OUTCOME WHEN WE AGE
BUT CAN BE PREVENTED!
Definitions

Fall
A fall is - “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level” (with or without the loss of consciousness).

Slip / Trip
Not only do we need to ask an older person if they have had a history of falls, but also if they are experiencing any slips, trips or stumbles.

Slip – to slide involuntarily and lose one’s balance or foothold
Trip – an accidental misstep threatening (or causing) a fall
Stumble - to step awkwardly while walking and begin to fall

Repeated slips trips or stumbles, can be warning signs of future falls.

We should not wait until a fall occurs before implementing falls prevention strategies. Early intervention could prevent future falls from occurring.

Un-explained fall
This is when a fall has not been witnessed, a cause cannot be identified or the person does not know how or why they fell.

It is of high priority that we identify clients who state they have had a “weak turn” or perhaps “fainted / blacked out” (unexplained fall). These occurrences may be an indication of an underlying medical problem, which will require medical attention.
Falls Osteoporosis and Fracture Facts

Falls, Osteoporosis and Fractures have serious consequences for an individual, affecting them physically, socially and psychologically.

- Approximately 30% of people over 65yrs of age and living in the community fall each year; the number is higher in institutions
- Those over 75 yrs of age are most at risk from falls, suffering both the highest mortality rate and the most severe injuries
- A large proportion of falls go unreported
- Less than one fall in 10 results in a fracture, a 1/5 of fall incidents require medical attention
- Falls are often a signal of unidentified healthcare needs in older people
- In Northern Ireland up to 1/4 of hip fracture patients die within one year of their accident
- Hip fractures cause more than 1,150 premature deaths each month in the UK
- The estimated cost of a single hip fracture patient is approx £25,424
- The cost of care for all fractures in the UK is approx. £1,630 billion per year
- It is estimated that over 3 million people in the UK has Osteoporosis
- 1 in 2 women and 1 in 5 men will experience an osteoporotic fracture within their remaining lifetime
- Following an osteoporotic hip fracture around 50% of patients lose the ability to live independently
- About 90% of osteoporotic hip fractures in both sexes result from a simple fall from standing height or less, while vertebral fractures are often triggered by routine daily activities such as bending or lifting light objects
- Leading an active lifestyle can half your risk of breaking a bone
- Fall related accidents are a predisposing factor in 40% of events leading to long-term institutional care in older people
- All patients located at long-term care institutions are at potential risk for osteoporotic fractures
SECTION ONE

STAFF INFORMATION
1.1 Falls Risk Factors

It is recognised that falls are a multifactoral problem for which no single intervention is likely to achieve the same degree of success as a holistic approach. Therefore, when asking someone regarding a recent fall, you want to ascertain all contributing factors to help identify appropriate risk reduction measures.

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

**Intrinsic**
- Age
- Fear of falling
- Deterioration in health, mobility, and strength
- Impaired gait or balance
- Medical conditions e.g.
  - Parkinson disease
  - Cerebral Vascular Accident
  - Osteoporosis
  - Hypotension
  - Incontinence
  - Osteoarthritis
  - Syncope
  - Dizziness/Vertigo
- Cognitive impairment and depression
- History of previous falls
- Alcohol misuse
- Polypharmacy - multiple medications, sedatives, tranquillisers, hypnotics
- Poor vision
- Poor nutrition and diet
- Badly fitting footwear and clothing
- Female gender

**Extrinsic**
- Uneven or slippery surfaces
- Loose mats or rugs
- Inadequate light (especially on stairs)
- Poor steps and stairway design and repair
- Lack of safety rails in-
  - Bathroom
  - Bedroom
  - Kitchen
- Inappropriate height of -
  - Chair
  - Beds
  - Toilets
- Trailing flexes and cables
- Broken equipment
- Unfamiliar environment
- Cluttered environment
- Pets

**Behavioural**
- Getting up in the middle of the night in the dark
- Rushing to answer the phone or door
- Standing to put on lower garments
- Over stretching and over reaching

These lists are not exhaustive.
1.2 Fear of Falling / History of Falls

Falls are the most common adverse event for our elderly population. It is estimated that 1 in 3 older people over the age of 65 and 1 in 2 over the age of 80 will fall every year. It has also been suggested that the psychological effects of falling “Post Falls Syndrome”, can sometimes be more damaging than the physical injuries that someone may sustain.

With the elderly, a fall may be associated with
- Fear of future falls
- Loss of confidence
- Restriction in activities
- Social withdrawal and loneliness / depression

If any of the above occur, it may result in a person becoming more sedentary, which in turn will affect their muscle strength and balance, and consequently increase their risk of a fall. Therefore, fear of falling must be addressed when trying to prevent future falls.

 Provision of the following information should be considered when addressing someone’s fear of future falls.
- Information regarding how to cope with a fall / long lie
- Assistive technology – pendant alarms / falls detectors
- Hip protectors
- Referral for assessment for mobility equipment
- Importance of keeping mobile
1.3 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. Some spinal fractures can be painless, and Osteoporosis may still go undetected until late stage complications occur e.g. Kyphosis – back deformity.

It is currently estimated that 1 in 2 women and 1 in 5 men will have a hip fracture due to Osteoporosis within their lifetime. The hip, wrist and vertebrae are the most common bones to break.

Bone is a living tissue, and is continually renewing itself. Constantly our bodies are breaking down old bone (re-absorption), and depositing/building new bone (formation). Approximately during the first two and half decades of life, formation of bone exceeds re-absorption, and by our mid twenties we will have reached our peak bone mass (greatest bone density). It is then after the age of 35 that bone loss begins to increase very gradually, as the cells responsible for breaking down bone begin to work more quickly than the cells responsible for building bone. This results in age related bone loss, if this loss becomes so severe, we can develop Osteoporosis.

Hip bone

Osteoporosis is often associated with increased age, but can be referred to as a paediatric disease with geriatric consequences. This is because the bone we lay down in those first decades of life will have a direct effect on our bone quality and strength in later years.

It is essential we attain as great a peak bone mass as possible to help prevent the development of Osteoporosis in later years.

Osteoporosis should not be viewed as an evitable part of the ageing process, but is a preventable illness of the older adult skeleton.
**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**

**Calcium**

Calcium is essential for the formation and maintenance of strong healthy bones and teeth. It is recommended that the calcium intake for adults is **700mgs** per day. Larger doses may be prescribed for patients who have had a fracture, or diagnosed with osteoporosis. Many foods contain calcium, but the best and easiest source for the body to absorb is found in dairy products.

<table>
<thead>
<tr>
<th>Food source</th>
<th>Calcium content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canned sardines in tomato sauce (100mg)</td>
<td>460mg</td>
</tr>
<tr>
<td>Glass of semi-skimmed milk (200ml)</td>
<td>248mg</td>
</tr>
<tr>
<td>Glass of whole milk (200ml)</td>
<td>237mg</td>
</tr>
<tr>
<td>Pot of low fat yoghurt (150g)</td>
<td>225mg</td>
</tr>
<tr>
<td>Piece of cheddar cheese (30g)</td>
<td>216mg</td>
</tr>
<tr>
<td>3 scoops of dairy ice cream (180g)</td>
<td>234mg</td>
</tr>
<tr>
<td>1 teaspoon of sesame seeds (12g)</td>
<td>80mg</td>
</tr>
<tr>
<td>Small can of baked beans (150g)</td>
<td>80mg</td>
</tr>
<tr>
<td>2 slices of white or brown bread (72g)</td>
<td>72mg</td>
</tr>
<tr>
<td>Cooked broccoli (90g)</td>
<td>34mg</td>
</tr>
</tbody>
</table>
**Vitamin D**

Vitamin D allows the body to absorb the calcium from our diet. Our main source of Vitamin D is sunlight.

The recommended level of vitamin D to prevent osteoporosis is 10mcg (400iu) per day, for older adults and those with osteoporosis a higher dose may be recommended.

Vitamin D is a fat-soluble vitamin and can be stored in body fat for use throughout the year. It is suggested that before applying sunscreen, expose face, hands and arms for 5-15 minutes each day, between the hours of 10am – 3pm during the summer months (May to October), to make enough vitamin D for the year.

There are also foods sources containing Vitamin D

- Oily fish
- Egg yolks
- Liver
- Foods that are fortified with vitamin D e.g. margarines, cereals and bread.

Many elderly people do not get the recommended daily calcium and/or Vitamin D. This can be due to poor diets, medical problems that affect absorption, or being housebound with no exposure to sunlight. A calcium and Vitamin D supplement is often recommended and can be prescribed by a G.P.

Eating a variety of foods, and having a well balanced diet, can assist our body in maintaining healthy bones and teeth, and can provide us with the necessary nutrients to help us maintain an active and healthy lifestyle.
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

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

Osteoporosis medication
There are 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. Examples are Bisphosphonates, S.E.R.M’S and Strontium ranelate, all of which must be prescribed by a G.P. / Consultant
1.4 Medication

Many medications have side effects that may increase the risk of falls among our elderly population.

Consideration must be given to the

- Type of drug
- Dose taken
- Length of time since commencement of a drug, as sometimes side effects only appear 2-3 weeks after commencement

This is a general guide regarding medication and falls. Further advice and information can be obtained from GP’s or Pharmacist.

Multiple Medicines (Poly Pharmacy)
People who are on four or more medicines, prescribed or bought, are at greater risk of having a fall. Appropriate professionals should review medications.

Change in Metabolism with age
Our liver and kidneys play a major role in the way our body metabolise tablets. As we get older these organs become less efficient. This can lead to an accumulation of tablets in the body and consequently prolonging the effects of the medication.

Low blood pressure (Hypotension)
Certain types of medications may cause a drop in blood pressure, when an upright position is assumed, lying to sitting or sitting to standing. This drop in blood pressure can cause dizziness, light-headedness or even a faint.

Steroid therapy
The administration of long-term steroid therapy, can contribute to bone fragility and subsequent fractures.

Calcium and Vitamin D supplements
Calcium and Vitamin D are necessary for strong bones, and in certain cases, especially in institutional care, may be prescribed to help reduce the severity of the injury if a fall occurs.

Vitamin D deficient
Increasing levels of vitamin D can improve neuromuscular function, reaction and strength in those who are Vitamin D deficient.
Medication Advice

- A lot of elderly people buy “over the counter/herbal” medications. They should be advised to check with the Pharmacist that these do not interfere with the medications that have been prescribed by their GP.

- 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.

- People should be advised to take Diuretics (water tablets) in the morning, to prevent having to get up at night to go to the toilet.

Obtaining a drug history

When obtaining a drug history from an elderly person, the following needs to be considered:

- How do they obtain their regular supply of medication?
- Do they have any difficulties opening containers?
- How many different types of medication does the person take?
- Can they follow the administration instructions?
- Do they take any “over the counter” medication?
- Do they experience any side effects from the medications?
- Do they actually take their medication and, if so, how?

Certain types of medication can contribute to an increase in the risk of falling, for example sedatives, antihypertensive and antidepressants. These medications should only be used for specific indications and for the shortest time necessary, as indicated by their G.P.

It is recommended that older people who are taking four or more different types of medication, should have them reviewed by a GP or Pharmacist.
This chart provides information on some medications that are associated with an increased risk of falling. The list is not exhaustive.

<table>
<thead>
<tr>
<th>HIGH RISK DRUGS</th>
<th>Condition used for</th>
<th>Common drug names</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Used for depression described as low mood, unable to cope, anxiety. Sometimes used for pain relief.</td>
<td>Amitriptyline, Dosulepin Lofeperamine, Trazadone, Citalopram, Fluoxetine (Prozac), Paroxetine (Seroxat), Sertraline.</td>
<td>Drowsiness, blurred vision, constipation, retention of urine.</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Mental illness of many types including disturbed patients, schizophrenia, dementia, aggression.</td>
<td>Chlorpromazine (Largactil), Haloperidol (Serenate), Promazine, Olanzapine Quetiapine, Risperidone.</td>
<td>Low blood pressure-dizziness on sitting or standing, drowsiness, hypothermia.</td>
</tr>
<tr>
<td>Anti-muscarinic</td>
<td>Shaking as in Parkinson’s disease, side effects of other drugs, urinary frequency, incontinence.</td>
<td>Orphenadrine, Procyclidine, Benzhexol, Oxybutynin, Tolteradine</td>
<td>Dizziness, blurred vision, retention of urine, confusion, drowsiness, restlessness, hallucinations.</td>
</tr>
<tr>
<td>Benzodiazepines and Hypnotics</td>
<td>Anxiety, calming, to help with sleep.</td>
<td>Diazepam (Valium), Chlordiazepoxide (Librium), Lorazepam, Oxazepam, Nitrazepam (Mogadan), Loprazolam, Lormetazepam, Temazepam, Zaleplon, Zolidem, Zopiclone.</td>
<td>Drowsiness, light-headedness the next day, confusion, loss of memory, nightmares, restlessness, staggering, delirium.</td>
</tr>
<tr>
<td>Drugs for Parkinson’s disease</td>
<td>Slow movement, rigidity, shaking.</td>
<td>Co-beneldopa, co-careldopa, selegiline</td>
<td>Sudden daytime sleepiness, dizziness, insomnia, confusion, low blood pressure – dizziness, shaking.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderate Risk Drugs</th>
<th>Condition used for</th>
<th>Common drug names</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors</td>
<td>High blood pressure, heart failure.</td>
<td>Captopril, Enalopril, Perindopril, Ramipril, Trandolopril</td>
<td>Low blood pressure-dizziness.</td>
</tr>
<tr>
<td>Angiotensin II antagonists</td>
<td>High blood pressure.</td>
<td>Losartan, Valsartan</td>
<td>Dizziness, tiredness.</td>
</tr>
<tr>
<td>Alpha-blockers</td>
<td>High blood pressure, prostate disease.</td>
<td>Doxazosin, Prazosin, Terazosin</td>
<td>Low blood pressure-dizziness, tiredness, sleepiness.</td>
</tr>
<tr>
<td>Anti-arrhythmics</td>
<td>Irregular heart beat, usually faster.</td>
<td>Digoxin, Amiodarone, Disopyramide, Flecanide</td>
<td>Dizziness, vision disturbance, tiredness, sleepiness. (Monitor for digoxin toxicity.)</td>
</tr>
<tr>
<td>Anti-epileptics</td>
<td>Epilepsy (seizures or fits), pain, mood stabiliser.</td>
<td>Carbamazepine, Gabapentin, Lamotrigine, Phenytoin, Phenobarbitone, Epilim (Sodium Valporate), Clonazepam</td>
<td>Dizziness, drowsiness, blurred vision, tiredness, shaking.</td>
</tr>
<tr>
<td>Anti-histamines</td>
<td>Allergies, hay fever, rashes, help with sleep.</td>
<td>Cetirizine (Zirtek), Desloratidine, Chlorpheniramine, (Piriton), Diphenhydramine, Promethazine</td>
<td>Sleepiness, blurred vision, retention of urine.</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>High blood pressure, angina (chest pain).</td>
<td>Propranolol, Atentolol, Bisoprolol, Sotaolol</td>
<td>Low blood pressure-dizziness.</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Fluid retention (swollen ankles, breathing problems.)</td>
<td>Bendroflumethazine, Indapamide, Furosemide, Bumetanide, Amiloride, Spironolactone</td>
<td>Low blood pressure, dizziness, confusion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk Drugs</th>
<th>Condition used for</th>
<th>Common drug names</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium Channel Blockers</td>
<td>High blood pressure, angina (chest pain).</td>
<td>Amlodipine, Diltiazem, Felodipine, Nifedipine, Verapamil</td>
<td>Dizziness, tiredness, drowsiness, vision disturbance.</td>
</tr>
<tr>
<td>Oral anti-diabetics</td>
<td>Type-2 diabetes-elderly onset.</td>
<td>Gibeclamide, Glicazide, Metformin</td>
<td>Dizziness if blood sugar low.</td>
</tr>
<tr>
<td>Proton pump inhibitors and H2 antagonists</td>
<td>Stomach ulcers, heartburn.</td>
<td>Omeprazole, Lansoprazole, Pantoprazole, Cimetidine, Famotidine, Ranitidine</td>
<td>Dizziness, blurred vision, confusion, tiredness, Avoid cimetidine in patients on other medicines.</td>
</tr>
</tbody>
</table>
1.5 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 options
- Medication review
- Movement from lying to sitting and sitting to standing, should be performed slowly
- Advise regarding adequate fluid intake, 2 litres daily unless contraindicated by medical conditions
- Eat small meals and snacks throughout the day rather than large meals
- Avoid constipation
- Review sodium intake. High levels of sodium may lead to hypertension (high blood pressure) and should only be recommended by a GP
1.6 Alcohol

Alcohol consumption in the over 60’s age group continues to be lower than any other age group, but the percentage of over 60’s who drink over the recommended limit is increasing. Alcohol consumption dulls neurological capacity, affecting balance and co-ordination, and consequently increases the risk of falls.

Currently it is estimated that alcohol is a factor in 33% of accidents that occur within the home.

How does Alcohol affect us?
This depends on various factors including gender, weight and age.

Alcohol concentration in the blood and the effects of alcohol will be felt more quickly and last longer in

- A woman, as their body is made up of more fat and less water than a man
- The older population, as they tend to lose fat and body weight with age

Recommended drinking limits (non age specific).

**Male**
No more than **3-4 units per day** and no more than **21 units** over the course of a week

**Female**
No more than **2-3 units per day** and no more than **14 units** over the course of a week.

It is recommended that units are spread throughout the week – you shouldn’t save them up!

What’s in a drink?

- Pint of lager 2 units
- Half pint of cider 1 unit
- Pint of stout 2 units
- Bottle of lager 1 ½ units
- Can of extra strong beer 4 ½ units
- Small pub bottle of wine 2 ¼ units
- Small glass of wine 1 ½ unit
- Northern Ireland pub measure of spirit 1 ½ units
- Alcopop / ready mixed drink 1 ½ units
1.7 Dementia / Cognitive Impairment

Many people who have a cognitive impairment and/or dementia may experience the following, putting themselves 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
- Life long habits
- Independence - need to be independent

This list is not exhaustive.

Assistive technology may be an option to consider in risk reduction.
1.8 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.

**Frequent bladder difficulties**
- Urgency of passing water
- Frequency of passing water
- Urinary Track Infection
- Taking diuretics (Water tablets)
- Incontinence

**Risk Factors**
- Slipping on wet surfaces
- Increased speed when walking to the toilet
- Frequent rising at night and disturbed sleep
- Getting up to the toilet in the dark during the night
- Difficulty adjusting clothing, especially if using mobility equipment
- Unable to stand unaided

**Risk reduction Options**
- Hip protectors
- Wears footwear to reduce slipping on urine
- Provision of a commode
- Medication review
- Continence advice
- Provision of appropriate sanitary wear
- Wear clothes that are easy to adjust.
- Diuretics (water tablets) should be taken in the morning to prevent frequent rising to the toilet at night
1.9 Exercise

Man does not cease to play because he grows old…
He grows old because he ceases to play.”

George Bernard Shaw

When demands on postural control are greater than a person’s capability, a fall will occur. They can happen at any stage of life, but as age increases they can become more frequent. A young fit person can normally correct a slip or trip, but as the body ages it no longer has good balance or righting mechanisms to prevent the fall from happening.

As we get older, our bodies begin to lose functions such as muscle strength, balance and co-ordination. This happens much more quickly if we live an inactive lifestyle. Much of this loss is simply though lack of use, but maintaining an active lifestyle can slow this loss.

Physical activity and exercise will help maintain an elderly persons balance, strength and flexibility. This in turn will help them to remain independent and enable them to perform their daily activities of living.

GOOD NEWS….. Research shows that even into our 80’s, the human body has the ability to respond well to appropriate physical activities. It is possible to turn the clock back by up to 20 years in terms of muscular and aerobic fitness in response to the right kind of training.

Our elderly population need to be careful about what exercise they do and how they go about it. Underlying medical conditions can affect or be affected by exercise.

It is recommended that people with a history of falls consult with their GP, or other specialists qualified in working with older people with a history of falls.
What Type Of Exercise Is Best?
It is important to exercise all the parts of the body that are involved in balance. This will also help you when getting down and up from the floor.

A combination of strength, co-ordination, endurance and balance training, offers benefits for people at risk of falls. To be beneficial exercise must be maintained and progressive.

Strength Activities
- Climbing upstairs
- Walking uphill
- Carrying shopping
- Housework

Endurance Activities
- Walking
- Cycling
- Dancing
- Swimming
- Housework (washing floors or windows)

Balance and co-ordination activities
- Dancing
- Yoga
- Pilates
- Tai Chi

Exercise is a must if you want to stay robust!

You lose it if you don’t use it!

If you rest you will rust!
1.10 Eyesight

Older people with sight problems are more likely to fall, and are at a greater risk of multiple falls compared to their fully sighted peers.

Many older people blame changes to their eyesight on ageing, but only an eye examination can separate a serious visual impairment from ‘normal’ ageing changes.

How can problems with vision lead to a fall?
A greater sensitivity to glare can lead to reduced clarity of vision, which reduces the ability to see and identify potential falls hazards, for example:
- Edge of a rug on a pattern carpet
- Stairs and steps

When an eye condition e.g. cataract, glaucoma or macular degeneration occurs in combination with age-related changes in vision, there will be a further loss of visual function.

In addition to age related vision loss, there are four main eye conditions that are associated with the elderly:
- Macular degeneration
- Cataracts
- Glaucoma
- Diabetic retinopathy
Macular Degeneration
The macula is a small area at the very centre of the retina (at the back of the eye). The macula is very important and is responsible for what we see straight in front of us, allowing us to see fine detail for activities such as reading and writing, as well as our ability to see colour.

Sometimes the delicate cells of the macula become damaged and stop working, and there are many different conditions, which can cause this. If it occurs later in life, it is called “age-related macular degeneration”, also often known as AMD.

The Impact of AMD on Sight
AMD is not painful, and almost never leads to total loss of sight. The degeneration of the macula can leave a central blind spot, which makes it difficult to read, watch television and recognise faces. However, the side (or peripheral) vision of those with AMD remains intact and, with practice, can be enough for people to maintain an independent life.

AMD is the most common cause of registered blindness for older people in the UK.

Symptoms of AMD
- Distortion of straight lines
- A blank patch or dark spot in the centre of vision

Treatment
People who think they may have this condition should visit their Optometrist /Optician, who will confirm diagnosis and make all necessary onward referrals. Low vision services can offer advice, support and equipment that will enable a person with reduced vision to continue living independently.

Cataract
A cataract is a clouding of part of the eye called the lens. Vision becomes blurred because the cataract is like frosted glass, interfering with sight.

Over half of those over 65 years old have some degree of cataract. Most cataracts that affect daily living can be treated surgically with a high success rate.

Signs that the client may have a cataract:
- Blurry sight – sight appears blurred or misty, glasses may seem dirty or scratched
- Dazzled by lights – such as car headlamps and sunlight
- Change of colour vision – washed out or faded

Treatment
The most effective treatment for cataract is an operation to remove the cloudy lens. However a good diet may help to slow the growth of age-related cataract.
**Glaucoma**
Glaucoma is a condition in which the optic nerve is damaged at the point where it leaves the eye. In most people the damage is caused by raised eye pressure.

There are 4 main types of glaucoma but Chronic Glaucoma is the most common. Chronic Glaucoma becomes much more common with increasing age. People with a family history and/or a high degree of short sight are more prone to Chronic Glaucoma and diabetes is believed to increase the risk of developing the condition.

**Symptoms of Chronic Glaucoma**
- In the earlier stages people do not notice any effect on their vision and there is no pain to show that there is a problem
- As the disease progresses damage to the optic nerve results in blank patches above or below the centre of the visual field
- Without treatment the blank patches enlarge and join, finally leaving only a small part of central vision (tunnel vision).

**Treatment**
The main treatment for Chronic Glaucoma aims to reduce the pressure in the eye. This is usually started with eye drops, it is very important to keep using eye drops. The eye specialist will then decide on the next step to take in each particular case.

Although damage already done cannot be repaired, with early diagnosis and careful regular observation and treatment, damage can usually be kept to a minimum and good vision can be enjoyed indefinitely.

**Diabetic Retinopathy**
This is a complication of diabetes mellitus, which affects the fine network of blood vessels in the retina. There are two types – maculopathy and proliferative diabetic retinopathy. These conditions both have different symptoms but each can cause considerable sight loss.

**Symptoms**
- In the early stages people do not notice any effect on their vision
- Maculopathy – the blood vessels in the retina begin to leak affecting central vision and making it difficult to recognise faces, see fine detail or read small print
- Proliferative - is more uncommon and occurs when blood vessels multiply in the retina leading to bleeding within the eye causing loss of vision. Eyesight becomes blurred and patchy and without treatment total loss of vision can occur.

**Treatment**
Most sight-threatening problems caused by diabetic retinopathy can be managed by laser treatment if it is given early enough. It is important to realise, however, that laser treatment can only preserve the sight you have – not make it better.

*Good control of Diabetes will reduce the risk of Diabetic Retinopathy*
Action Points For Staff

- If the client has had a fall – ask if they have had a recent eye test
- Encourage regular eye examinations – once a year if someone is at risk of falling
- Encourage clients to look after their glasses
  a. Clean glasses regularly
  b. Only wear their prescribed glasses
- Identify local Optometrists/Opticians who offer domiciliary visits
- Referral to Rehabilitation and low vision services who can help maximise independent living
- Ensure that clients with glaucoma or diabetes are accessing services and taking their medication or inserting eye drops correctly. Eye drop bottle holders may be beneficial to clients with restricted arm movements or those who live alone and are afraid of instilling the drops themselves
- Home Safety Checklist can be carried out to identify where risks exist and changes need to be made. Simple changes within the home can help to prevent falls such as
  a. Improved lighting within the home
  b. Reorganising furniture and removing clutter
  c. Avoiding upholstery and floor coverings that have patterns, stripes and checks, which can create confusion for people with sight problems
  d. Remove mats with turned up edges and remove frayed carpe
- Encourage clients to look after their overall health
  a. Protecting eyes from the sun
  b. Eating a well-balanced diet with plenty of fresh fruits and vegetables
  c. Stopping smoking

All the above may help to delay the progress of eye conditions
1.11 Hearing

Older people with hearing problems that may affect balance and concentration are more likely to fall. In this section we will look at Vertigo and Tinnitus, but this list is not exhaustive.

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.

Symptoms
Vertigo can develop suddenly and last for minutes, or days. The symptoms may be on and off or constant, and include

- A feeling your surroundings are moving or spinning
- Nausea
- Vomiting
- Difficulty in standing or walking
- The sensation of light-headedness
- The sensation of not being able to keep up with what you are looking at
- The sensation that the floor is moving

Treatment
Treatment will depend on the cause of problem, and may consist of antibiotics for the infection and antiemetics (anti sickness tablets) for the nausea.

The following self-help techniques may help to relieve or prevent the symptoms of vertigo
- Sleep with the head slightly elevated on two or more pillows
- In the morning, get up slowly and sit on the edge of the bed for a minute before standing
- Avoid bending down to pick up items
- Avoid extending the neck, for example, while reaching up to a high shelf
- Move the head gently and slowly during activities where the head is lying flat or the neck is extended
**Tinnitus**

Tinnitus is the perception of noise in the ear or head, which is generated inside the body rather than coming from outside, and is usually only heard by the person who has the condition. The most common cause of tinnitus is damage to the hearing nerves in the ear. In older people it is usually caused by natural hearing loss, which lessens the sensitivity of the hearing nerves.

Temporary tinnitus is common if someone has a cold, and after exposure to loud noises.

**Symptoms**

The sounds heard by people with tinnitus vary but include intermittent or continuous ringing, hissing, whistling, roaring or buzzing noises.

**Treatment**

In most cases there is no cure, and treatment is designed to help people manage tinnitus on a day-to-day basis. Some people find that certain medication may trigger tinnitus, if so; their GP may discontinue or change it. It is suggested that tinnitus is strongly linked to stress, and sometimes people are prescribed sedatives, tranquillisers or antidepressants to lessen the effects on their lives.

Some other things that may prove effective in controlling tinnitus:

- Listening to calming music on personal headphones, especially at bedtime
- White noise generators (tinnitus maskers)
- Use of a hearing aid if you have slight hearing loss. Being able to hear sounds that you cannot normally hear, may help to override the tinnitus noise
- Deliberate effort to concentrate on something else and ignore the tinnitus
- Cognitive behaviour therapy by a hearing therapist to help people to change their response and lower their awareness of tinnitus

**Generic advice for staff members**

- Encourage regular hearing tests
- Check that hearing aids are working, being used correctly and batteries are changed
- Face the person when speaking
- Speak clearly and not too fast
1.12 Foot Care/Footwear

Some common problems
- 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
- Observe any abnormal changes in colour, unusual swelling or breaks in the skin. If an infection is suspected contact the patient’s G.P. or podiatrist immediately
- 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
- If an infection is suspected the GP or Podiatrists should be contacted immediately

Footwear
Suitable footwear that is properly designed and fitted will protect the foot and support foot function. This is important for maintaining independent mobility and preventing falls. Inappropriately fitting footwear can cause corns, callus, ingrown toenails ulcers, bunions and hammer toes. These make walking difficult and can precipitate a fall by creating an unsteady gait. A good fitting shoe is the most important factor in preventing a fall.

Points to consider, when choosing a supportive and safe shoe
- Soles should be flexible, textured and cushioned to aid grip, avoid leather
- Avoid high heels
- Leather or suede uppers are best, with laces, buckles or Velcro straps. These hold the feet firmly in place, preventing them from slipping forward
- Laces should be tied comfortably and securely
- A shoe with a high collar may provide additional ankle support
- Regularly have feet measured for length and width to ensure a correct fit. Foot shape can change as we age
1.13 Environment

A variety of accidents can occur within the home. Statistics for those aged over 65, indicate that 71% of home accidents are due to falls. Falls have also been identified as the highest cause of accidental death within the home environment.

When individuals are fit, activities within the home can be completed with little effort or thought. Sometimes due to ill health or reduced mobility these activities may become more challenging and may increase a persons risk of having an accident. Small changes in the home environment can reduce that risk.

General principles to consider within the home environment can include

Balance
- Adapt the home to reduce the need to bend too low, stretch too high or change position too quickly

Tripping/slipping
- Can the individual move around the home freely
- Are rugs removed or secured
- Is footwear supportive with non-slip soles
- Are the main walkways free from clutter

Lighting
- Ensure the home is well lit during the day and night especially the stairs
- When rising during the night, always use a light

Furniture
- Is the bed, chair and toilet at an appropriate height to allow easy use

Additional information is provide in Section Four – Information leaflets

“Making your Home Safer”
SECTION TWO

RISK ASSESSMENT
2.1 Risk Assessment

To address falls prevention we must
   - Identify individuals at risk
   - Implement appropriate risk reduction measures

According to guideline in Falls-The assessment and prevention of falls in older people, “Older people who come in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of fall/s”

The following tools may be utilized
   - F.R.A.T. (tool 1) – to help staff identify those who are at risk of falling
   - Intervention tool (tool 2) – to help guide staff regarding appropriate risk reduction measure

Assessment should be reviewed / updated according to need.
2.2 Falls Risk Assessment - Tool 1

Notes for users:

1) Complete assessment form below. The more positive factors, the higher the risk of falling.

2) If there is a positive response to three or more of the questions in Tool 1, then the Falls Intervention - Tool 2 must be completed, and appropriate referral options identified.

3) If less than three positives, and you remain concerned about the persons risk of falling, complete Falls Intervention - Tool 2.

NAME: ___________________________________________ DATE of BIRTH: ________
ADDRESS: __________________________________________

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 1 | Is there a history of any falls in the previous year?  
**How assessed?** Ask the question |     |    |
| 2 | Is the person on four or more medications per day?  
**How assessed?** Identify number of prescribed medications |     |    |
| 3 | Does the person have a diagnosis of stroke or Parkinson’s Disease?  
**How assessed?** Ask the person |     |    |
| 4 | Does the person report any problems with their balance?  
**How assessed?** Ask the person. |     |    |
| 5 | Is the person unable to rise from a chair of knee height?  
**How assessed?** Ask the person to stand up from a chair of knee height without using their arms |     |    |

**Falls Risk Assessment - Tool 1 score**

*Developed by Nandy S, Parsons S et al*

Completed by ___________________________ Date ________________
2.3 Falls Intervention - Tool 2
NAME: ________________________________ DATE of BIRTH: ________
ADDRESS: ________________________________

Assess the risk factors in the first column, address the interventions in the middle column, then consider the referral options in the last column.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Interventions</th>
<th>Referral Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falls</td>
<td>Discuss recent and previous falls and try to identify causes</td>
<td>OT</td>
</tr>
<tr>
<td>/ Fear of falling</td>
<td>If an “unexplained fall” refer to GP</td>
<td>PHYSIO</td>
</tr>
<tr>
<td></td>
<td>Discuss ability to rise from the floor following a fall</td>
<td>CRT</td>
</tr>
<tr>
<td></td>
<td>Give leaflet regarding a long lie</td>
<td>HFH</td>
</tr>
<tr>
<td></td>
<td>Discuss use of pendant alarms</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Discuss use of hip protectors</td>
<td>SW</td>
</tr>
<tr>
<td></td>
<td>Discuss the importance of keeping mobile/active</td>
<td></td>
</tr>
<tr>
<td>2. Medication</td>
<td>Consider need for medication review</td>
<td>PH</td>
</tr>
<tr>
<td>Takes 4 or more different</td>
<td>Check if there are any difficulties with administration /collection of</td>
<td>GP</td>
</tr>
<tr>
<td>types of medication per day</td>
<td>medication</td>
<td>SW</td>
</tr>
<tr>
<td></td>
<td>Inform regarding “over the counter” medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss regarding the role of the Community Pharmacist</td>
<td></td>
</tr>
<tr>
<td>3. Postural Hypotension /</td>
<td>Inform regarding the need to stabilise self after changing position and</td>
<td>GP</td>
</tr>
<tr>
<td>dizziness</td>
<td>before walking (lying to sitting / sitting to standing)</td>
<td>TR</td>
</tr>
<tr>
<td></td>
<td>Consider referral for measurement of lying/standing blood pressure</td>
<td>PCNT</td>
</tr>
<tr>
<td>4. Alcohol</td>
<td>Establish current intake of alcohol</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Raise awareness of the risk of taking alcohol along side medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss falls associated with alcohol</td>
<td></td>
</tr>
<tr>
<td>5. Mobility</td>
<td>Check if there has been a recent deterioration in mobility</td>
<td>OT</td>
</tr>
<tr>
<td></td>
<td>Consider their ability to rise from the floor following a fall</td>
<td>PHYSIO</td>
</tr>
<tr>
<td></td>
<td>Refer for mobility assessment</td>
<td>CRT</td>
</tr>
<tr>
<td></td>
<td>Discuss the importance of keeping mobile and active</td>
<td>HFH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP</td>
</tr>
<tr>
<td>6. Footwear / Foot Care</td>
<td>Discuss dangers of wearing loose fitting/non supportive/high heeled/open</td>
<td>POD</td>
</tr>
<tr>
<td></td>
<td>backed shoes or ‘sloppy’ slippers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advise to wear good supportive non slip footwear both in doors and out</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider referral to podiatry services</td>
<td></td>
</tr>
<tr>
<td>7. Sensory Impairment</td>
<td>Inform regarding the need for regular eyesight testing</td>
<td>OPT</td>
</tr>
<tr>
<td>(Visual / hearing)</td>
<td>Advise that glasses should always be clean and worn</td>
<td>RWVI</td>
</tr>
<tr>
<td></td>
<td>Advise caution in use of bifocals / varifocals</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Consider referral to Rehabilitation worker for the visually impaired</td>
<td>TR</td>
</tr>
<tr>
<td></td>
<td>Consider the need for referral if hearing difficulties are present</td>
<td>AUD</td>
</tr>
<tr>
<td>8. Continence problems</td>
<td>Advise not to rush to the toilet</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Encourage use of prescribed continence aids</td>
<td>CAS</td>
</tr>
<tr>
<td></td>
<td>If required, make onward referral through GP for continence assessment</td>
<td>PCNT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DN</td>
</tr>
</tbody>
</table>
NAME: _________________________________ DATE of BIRTH: ________

ADDRESS: ________________________________

9. Nutrition / Osteoporosis
☐ Discuss dietary intake
☐ Refer for additional support of chilled meals
☐ Discuss the importance of calcium and vitamin D
☐ Advise regarding the effects of smoking and high alcohol intake in relation to bone health
☐ Make onward referral if weight loss has been noted
☐ Give leaflet regarding Osteoporosis

10. Cognitive Impairment
☐ Advise client/family member regarding availability of assistive technology
☐ Consider referral to GP for further investigations

11. Environment
☐ Ask if they are having difficulties using the toilet/bath/shower/chair or climbing stairs
☐ Advise regarding dangers of torn/loose carpets, mats/rugs, cluttered walk ways and trailing flexes/leads
☐ Advise need for sufficient lighting in the home, especially on stairs/corridor.
☐ Advise the need to switch on bedside light during the night.

<table>
<thead>
<tr>
<th>Onward Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUD</strong></td>
</tr>
<tr>
<td><strong>CAS</strong></td>
</tr>
<tr>
<td><strong>CCN</strong></td>
</tr>
<tr>
<td><strong>CRT</strong></td>
</tr>
<tr>
<td><strong>DENT</strong></td>
</tr>
<tr>
<td><strong>DN</strong></td>
</tr>
<tr>
<td><strong>DT</strong></td>
</tr>
<tr>
<td><strong>ETO</strong></td>
</tr>
<tr>
<td><strong>GP</strong></td>
</tr>
<tr>
<td><strong>HFH</strong></td>
</tr>
<tr>
<td><strong>OPT</strong></td>
</tr>
<tr>
<td><strong>OT</strong></td>
</tr>
<tr>
<td><strong>PCNT</strong></td>
</tr>
<tr>
<td><strong>PH</strong></td>
</tr>
<tr>
<td><strong>POD</strong></td>
</tr>
<tr>
<td><strong>PHYSIO</strong></td>
</tr>
<tr>
<td><strong>RWVI</strong></td>
</tr>
<tr>
<td><strong>SS</strong></td>
</tr>
<tr>
<td><strong>TR</strong></td>
</tr>
</tbody>
</table>

Comments

Support, Advice and Information Contacts

| Age Concern | 028 9024 5729 | National Osteoporosis Society | 028 9082 7780 |
| Help the Aged | 028 9023 0666 | Support Group Northern Ireland | 028 9066 4100 |
| RoSPA | 028 9050 1160 | Alzheimer’s Society Northern Ireland | 0845 450 0230 |

Has the person given consent for onward referral?
YES ☐ NO ☐

Completed by ____________________________ Date ____________________________
SECTION THREE

FALLS REGISTER


3.1 Recording a fall

It is important that accurate details are recorded when obtaining a falls history. The following information will help to
- Ascertain why the fall occurred
- Identify risk areas
- Implement risk reductions measures

Examples of necessary falls history information

- Number of falls in past year
- Location of fall
- Time of the fall
- Contributing factors of the fall
- loss of consciousness
- Any injuries sustained
- Did the injuries require medical / hospital attention
- Has the fall/s affected the persons confidence to mobilise
3.2 Falls Register

**Definition of a fall** – an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. (With or without the loss of consciousness)

This form should be reviewed at the end of every month.

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE / TIME</th>
<th>LOCATION</th>
<th>ACTIVITY</th>
<th>ANY CONTRIBUTING FACTORS</th>
<th>ANY INJURY</th>
<th>REFERRED / ADMITTED (A&amp;E / GP)</th>
<th>FALLS ASSESSMENT COMPLETED / REVIEWED</th>
<th>NEW INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.3 Falls Register Analysis

<table>
<thead>
<tr>
<th>MONTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF FALLS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME OF FALL</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0800 – 1300</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1300 – 1700</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1700 – 2100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2100 – 0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000 - 0800</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION OF FALL</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedrooms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilets/Bathrooms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lounges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corridors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dining Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INJURIES SUSTAINED</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruises</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuts &amp; Laceration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured Hip</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured Vertebrae</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured Wrist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total No. of Fractures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REFERRALS:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### IDENTIFICATION OF FREQUENT FALLERS (Two or more falls in any given period)

<table>
<thead>
<tr>
<th>NAME OF RESIDENT / CLIENT</th>
<th>NUMBER OF FALLS</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed by: ______________________ Date: __________________________
SECTION FOUR

INFORMATION LEAFLETS
4.1 Osteoporosis

It is a disease where over a period of time your bones become very porous and fragile. This increases an individual's risk of fracturing (breaking) a bone, and common sites are the spine, wrist and hip. It is a disease that is both preventable and treatable. So what can you do to help your bones?

**EAT A BONE FRIENDLY DIET**

- Calcium is necessary for building and maintaining strong bones. The main source of calcium comes from our diet. Foods rich in calcium include milk, cheese, yoghurts and other dairy products.
- Vitamin D is essential for the absorption of calcium, and can be found in oily fish (salmon, sardines, mackerel) and margarine. It is known as the sunshine vitamin, as the best source is sunlight.

**STOP SMOKING**

- Smoking decreases the bodies' ability to absorb calcium.
- Smoking can affect the cells that build new bone, making bones weaker.

**ENSURE A SENSIBLE ALCOHOL INTAKE**

- Excessive alcohol decreases the bodies' ability to absorb calcium.
- Alcohol can interact with medication, and increase susceptibility to falls.

**EXERCISE**

- Weight bearing exercises can help to stimulate new bone growth.
- Simple exercise like walking or climbing the stairs can be helpful.
- Exercise can improve balance and co-ordination.
4.2 What should I do if I fall?

- Don’t panic – try to stay calm
- Assess the situation – if you are hurt or feel unable to get up, follow THE REST AND WAIT PLAN.
- If you are unhurt and know you are able to get up, follow THE UP AND ABOUT PLAN.

THE REST AND WAIT PLAN

- Try to summon help
  - Use a pendant alarm if you have one
  - Bang on the wall
  - Call out for help
  - Crawl towards your phone and dial 999
  - Move to a soft surface such as carpet

- Keep Warm
  - Try to reach for something to cover yourself
  - Try to move out of draughts
  - Do not lie in one position for too long, as you may get cold or could develop a pressure sore
  - Roll from side to side and move your arms and legs if possible – this will help to keep you warm

If you need to empty your bladder while on the floor, use something such as tissue or an item of clothing to soak up the wet. If it is not too painful for you, move away from the wet area.

THE UP AND ABOUT PLAN

- Roll onto your hands and knees and crawl to a stable piece of furniture such as a bed stool or chair
- With your hands on the support, place one foot flat on the floor, bending your knee in front of your tummy
- Lean forward, push on your hands and feet, and bring your feet together
- Turn and sit on the seat. Rest for a while before getting up
4.3 Hip Protectors

Hip protectors are designed to protect the hip during a fall, and help to reduce the risk of a hip fracture.

Hip protectors are underpants that have padding or a padded shell covering the hip areas. The padding will help to disperse or absorb the impact of a fall, helping to protect the hip.

For hip protectors to be effective they must have been worn at all times.

Additional care must be taken when putting hip protectors on. Sit whilst putting your legs into the garment, and then stand to make final adjustments.

For purchase/availability, please contact your local Pharmacy.
4.4 Pendant Alarms

One of the main concerns you may have regarding a fall; is that no one finds you for a period of time. A pendant alarm can help prevent a long lie, and provide you with confidence to remain living independently within your own home.

A pendant alarm is a button you push in the event of an emergency.

You will need a telephone line, and usually details of two people who can be contacted in an emergency. If the button is pressed it will immediately connect you to a team, who will contact you and summon the help required.

For available sources, contact your local Social Services for advice and assistance.

It is important that you wear your pendant alarm at all times.
4.5 Bed and chair monitors

The bed and chair alarm systems are developed to alert a carer, by alarming, when someone leaves their bed or chair. They can be linked to the nurse call system in nursing home settings.

For further information, please contact

Occupational Therapy Department
Tardree House
Holywell Hospital
Antrim
Tel: 028 9441 3463

OR

Dementia Services Occupational Therapy
Rosebrook House
Brook Street
Coleraine
BT52 1QG
Tel: 028 7034 3084
4.6 Medication

Taking four or more different types of medication is a contributing factor to falls.

- Are you having difficulty collecting your regular supply of medication?
- Are you having problems following the administration instruction of your tablets?
- Are you having difficulty opening your tablet bottles or packaging?
- Do you feel light headed, dizzy or faint whilst on your medication?

If YES to any of the above, please contact your General Practitioner or Pharmacist to have your medication reviewed. Medications bought over the counter must also be considered.

**Medication – stay alive only use it as prescribed**
4.7 Exercise

Safety tips

- It is a good idea to check with your GP before starting a new exercise
- Wear comfortable clothing that does not restrict movement
- Wear comfortable supportive shoes with soles that are firm - not rigid. Laced trainers/shoes are best
- Single lens glasses rather than bifocals or varifocals are recommended when exercising
- Do not exercise if you are feeling unwell

If any of the following symptoms occur when exercising and STOP! Seek medical advice from your GP.

- Heart palpitations
- Chest pain
- Severe breathlessness, nausea or dizziness
- Fainting during or just after physical activity
4.8 Making Your Home Safer

The following are considerations.

**Hallway/Stairs**
- Are hallways/stairs well lit, especially at night?
- Are hallways/stairs clear and free of clutter?
- Are there banisters/handrails on both sides of the stairs?
- Are the light switches located at both the top and bottom of the stairs?
- Are floor coverings in good condition?
- Avoid heavy pattern carpet/floor covering
- If using a walking aid, is one available upstairs and downstairs

**Kitchen**
- Is the kitchen well lit?
- Are floor coverings in good condition?
- Are regularly used items stored within easy reach?
- If you have a kitchen trolley is it safe and in good working order?
- Wipe up all spill immediately

**Living Room**
- Is the living room well lit?
- Are floor coverings in good condition?
- Avoid heavy pattern floor coverings
- Remove and secure rugs
- Remove castors from furniture
- Flexes should be secured and not trailing across walkways?
- Keep your telephone within easy reach
- Is the furniture arranged to allow ease of movement with walking aids?
- Is the chair easy to get up from?
- Take your time getting up out of the chair
Bedroom

- Have access to bedside lamp – “touch lamp”
- Is the bed a suitable height?
- Ensure the bed does not move when sitting on it
- Are bedclothes trailing on the floor? If so, remove due to trip hazard
- Ensure bed covers are not slippery
- Ensure access to a telephone in the bedroom (moving from lying to sitting)
- Is a chair available to sit on when dressing?
- Ensure worn items of clothing stored within easy reach

Bathroom

- Ensure the bathroom is well lit
- Ensure soap and toiletries within easy reach
- Do you have difficulty using the toilet, bath or shower? Specialist equipment may be beneficial from Community Occupational Therapy
- Ensure that bath mats are removed or secure
- Ensure the use of a non-slip bath or shower mat

This is not an exhaustive list
4.9 Eyesight

It is important that we can see potential falls hazards within the home.

- If you are at risk of falling eyes should be tested every year
- Remember eye tests are free to the over 60’s
- Always wear your own glasses. Label within nursing homes
- Look after your glasses. Clean them regularly
- Watch out for bifocal or varifocal glasses, it may take a few days for eyes to adjust to looking through the correct part of the glasses
- Beware of hazards around your home
  - Remove clutter and trailing flexes
  - Remove mats with “turned up” edges and frayed carpets
- Always remember your eye drops. Eye drop bottle holders can be purchased from your chemist/eye clinic; these will help you put the eye drops in
4.10 Footwear

THE PERFECT SHOE – WHICH STYLE?

**HEEL**
- Wide base for stability
- Avoid stiletto heels
- No more than 1” height. (Higher heels put more pressure on the ball of the foot)

**LACES** – TO FASTEN ACROSS IN-STEP AND STOP FOOT SLIDING FORWARD
- Tie correctly with foot supported on chair
- Untie before removal
- Velcro strap or buckle are also suitable

**UPPER**
- Round toe
- Avoid hard seams and decorative stitching
- Choose leather or soft material. “Basket weave” uppers mould to fit misshapen toes
4.11 Foot Care

SKIN CARE

- **DRY SKIN** – Can occur regularly on the feet. Apply a moisture cream daily

- **SWEATY SKIN**
  - Dab with a little Surgical Spirit
  - Avoid Synthetic Footwear and Hosiery

- **CORNS & CALLOUSES** – Follow the Podiatrists’ advice

- Do not use Corn Paints or Plasters

NAIL CARE

- Nails should be cut following the shape of the end of the toe

- After cutting, nails should be filed with an emery board

- Do not cut down the sides of the nails

- Do not cut nails very short
SECTION FIVE

REFERENCES
5 References

AGILE, ACPC, OCTEP, 1998 Guidelines for the collaborative, rehabilitative management of elderly people who have fallen. Chartered Society of Physiotherapy, London


Bath and North East Somerset Primary Care Trust – Falls Risk Screening Tool
Burntwood, Lichfield and Tamworth Primary Care Trust and Age Concern South Staffordshire – Falls Risk Assessment Tool


Derby City and Derbyshire Health and Social Services – Falls Risk Assessment for Older People, screening tool


Economic cost of hip fracture in the UK (2000) The paper was commissioned by Health Promotion England on behalf of the Department of Trade and Industry from Steven Parrott, Research Fellow, Centre for Health Economics, University of York. June 2000

Economics of fragility fractures. Mr James Elliott. PowerPoint presentation, unpublished data


Health Promotion Agency. Focus on Alcohol - A guide to drinking and health. Belfast


Institute of Alcohol Studies. Fact sheet - Alcohol and the elderly http://www.ias.org.uk


Know your units http://www.knowyourlimits.info/YourUnits.aspx


National Dairy Council. The Calcium Story. www.milk.co.uk

National Dairy Council. The Calcium Counter www.milk.co.uk


National Osteoporosis Society. Exercise, Osteoporosis and Preventing Broken Bones. www.nos.org.uk


Northumberland National Health Service Falls Service – Level 2 Assessment

RoSPA Northern Ireland: “Home is where the Harm is” training video and DVD. Older People and Falls Section, Dr Beringer. 2004

Royal West Sussex National Health Service Trust and Western Sussex Primary Care Trust – Falls Risk Assessment Tool level 1 & level 2


South Devon Healthcare National Health Service Trust and Torbay Council – Falls Risk Assessment check list

Southport and Formby, National Health Service, Primary Care Trust – Falls Intervention Tool over 65’s August 05


United Hospitals Trust, Unpublished data


Welwyn Hatfield Primary Care Trust – Falls Screening and Referral Tool


Windsor, Ascot & Maidenhead Care Home – Falls Register

Steering Group

The development of this resource pack and intervention tool has been achieved through multidisciplinary work.

We would like to take this opportunity to thank the following individuals for their contribution.

**Sharon Love** - Falls Injury Prevention Nurse

**Cathy Patterson** - Community Consultant Geriatrician

**Fiona Morrow** - Senior Occupational Therapist

**Leesa Houston** - Senior Health Promotion Officer

**Daniel McCloy** - Senior Podiatrist

**Andrea Garner** - Senior 1 Physiotherapist

**Lisa Carolan** - Senior 1 Physiotherapist