FALLS CARE PLAN

To reduce likelihood of falls in care homes whilst maintaining dignity and independence

Name: Hickory Dock		**ID No: 1111111** **Date of Birth: 02/09/1905**	
Staff name: Ex Caliber		**Staff initials: EXC**	
Staff name:		**Staff initials**	
If Yes to any of the 6 questions below, complete and implement the falls care plan			
1. History of falls before or since admission?	X	**2. Walking unsteadily/unsafe to walk alone?**	X
3. Resident taking tablets to calm them or help them sleep?	X	**4. Resident or relative anxious about falls**	
5. Resident confused/ disorientated?	X	**6. Resident incontinent/ needing toilet frequently?**	

Falls history What were they doing just before the fall? Where did the fall occur? Do they reliably call for assistance when needed? If fall witnessed document account	Details: HD was walking to the dining room for lunch and had to wait in line to be seated. After a few minutes HD slumped to the ground, did not hit head and managed a slow descent by leaning on the wall to go down

Recommendations	**Action Taken include review actions**	**Initials**	**Date**	**Review date**
Unfamiliar Environment: Introduce to environment, particularly toilets and washing facilities. For some residents this could be daily requirement	Daily reminders to use call bell HD shows staff each am ability to use bell. On the way to day room HD reminded about where nearest toilet is	EC	20/12/22	
Place: Accommodate resident where they will most easily be observed	HDs room is near the office and HD happier if door open. In day room HD's chair is by the window as HD enjoys looking out & staff can see HD	EC	20/12/22	
Regular monitoring: At hand over consider need for this and at which intervals it is most appropriate – this may change on daily basis. Use appropriate form to record monitoring	Day time monitoring not required HD settles well in day room & staff observe Night time 2 hourly intentional rounding, if awake HD asked IR questions	EC	20/12/22	
Eyesight and Hearing: Ensure glasses and hearing aids are clean, worn and/or within easy reach. Refer on if appropriate	HD had vision check by visiting optician11/11/2019 usually wears glasses during mobilising may need reminding to wear and clean them – staff to prompt	EC	20/12/22	
Bed/Chair: If likely to fall out of bed, ensure the bed is at its lowest possible height unless this will reduce mobility or independence, check mattress. Refer to zone team if issues remain. Consider the need for a chair of appropriate height and design	Standard 3' bed with added side assist rail means HD is independent in & out of bed. Armchair in room is 19" to top of cushion which means HD is slowly independent in & out of chair. Staff need to remind him to reverse back to chair and use arms to sit down slowly	EC	20/12/22	
Medication: Medication should be reviewed 6 monthly for those over 75 and on 4+ meds. Yearly for under 75s	GP review of medications requested as none in last 12 months	EC	20/12/22	
Handover: Ensure staff are informed of resident's falls risk at each handover and any recent changes in circumstance – think – ReStore 2	Staff reminded to be observant re any changes in HDs behaviour & of HDs increase risk particularly early evening if displaying sundowning behaviour	EC	20/12/22	

Mobility: Ensure walking aids are appropriate and kept within reach. Refer on to physio if concerned. Mobilise regularly.	HD uses wheeled frame usually independently but may leave it too soon on returning to chair all staff to remind HD to reverse in until legs touch chair and use arms to gently sit	EC	20/12/22	
Footwear: Ensure resident has and is wearing appropriate footwear where applicable: secure fit, non-slip, no trailing laces. Consider non-slip slipper socks for those at risk of falling at night	HD been agitatedly removing shoes - staff found leather has deteriorated Daughter buying new Velcro fastening shoes for HD - staff to ensure that HD has non-slip slipper socks on at night as HD does not remember slippers when going to the toilet at night	EC	20/12/22	
Lighting: Check resident's ability to operate lights and sufficient brightness to allow safe mobilising	Exit sensor in HDs bed linked to table lamp so lights when HD exits bed	EC	20/12/22	
Confusion/disorientation: Refer any deficit/increased confusion to GP. Increase supervision. Offer appropriate productive occupations e.g. activity groups. Be aware acute confusion may indicate infection. Check resident's temperature and send sample to GP or refer	HD prone to early evening sundowning – staff to monitor any changes to this and discuss with senior team lead to see if action required. Previously prone to UTIs that increase confusion Early evening HD can be distracted with memory box & singing, also likes to help drawing curtains at night	EC	20/12/22	
Communication: Do they have difficulty understanding verbal instructions or questions? Speak clearly, use simple instructions, physical gestures and prompts. Repeat instructions if they can't remember ***	At times HD uses a picture chart to communicate he needs the toilet or needs a drink. Use clear simple instructions.	EC	20/12/22	
Toilet: If falls associated with resident's toileting, a routine of toilet visits may be helpful	If awake at night staff ask IR questions and assist with toileting as required. HD normally independent but if very sleepy due to timings of meds staff to assist	EC	20/12/22	
Lying and Standing Blood Pressure: Refer any dizziness symptoms to GP Advise resident to change position slowly	L/Standing bp taken each week and noted in care plan if drop noted reported to senior team lead and staff informed of increased falls risk	EC	20/12/22	
Behaviours: Does this person exhibit challenging behaviours that staff struggle to cope with? What helps? Do they get agitated? If so when and what helps to calm them Is a referral to the Care Home Education Support (CHES) team required?	HD can be calmed early evening with memory box & singing, also likes to help drawing curtains at night. HD enjoys watching the activity from the day room armchair and will join with singing and watching activity groups	EC	20/12/22	
Inform: Provide Age UK's' Staying Steady' leaflet to resident/relative/carer and engage them in this care plan. Check contact wishes in the event of a fall and complete incident form	Daughter to be contacted 24/7 in the event of HD falling. She visits 3/7 and HD is very settled during this time. At the end of the visit HD walks her to the front flower bed and then to the car, if dry. Staff member then assists HD back to day room for a cup of tea	EC	20/12/22	

Please use in conjunction with ReStore 2

Reassess monthly, after any fall or any change in circumstances

use new sheet if required