PROJECT REPORT
Falls in care homes
April 2008-March 2009

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Summary

Falls of residents in care homes account for a substantial proportion of the official major injuries accident notifications received by this District Council. Significant cost is incurred the NHS in treating these injured persons. The aim of this project was to reduce the likelihood of residents falling in care homes by promoting best practice.

Method

Falls accident notifications relating to care homes were investigated and the possible preventive measures discussed. An analysis of these accidents was produced under the headings of accident details, costs, and relevant control measures. Two meetings were held with other agencies working to control such falls. It is planned next financial year – 2009/2010 – to seek to work with such agencies to further establish what is best practice and promote this in the industry.

Resources

The equivalent of three weeks of an inspector's time was spent on this project.

Observations

1. A suitable resident care plan is a key control. All seven care homes visited had care plans, but they varied considerably in their content. Maybe there is a need for more guidance in this area.
2. Falls often lead to residents being in Hospital for a month at great cost to the NHS.
3. Some care homes find that pressure alarm pads are a useful way to be alerted when a resident gets out of bed.
4. There is a difficult balance to be struck between restricting / protecting residents and allowing them to enjoy as much freedom as possible. Medication and physical controls maybe used to reduce risk of falls but lead to a loss of quality of life.
5. Reviews of medication by the local GP vary. Some care homes review only annually with the local GP. Maybe there is role here for a highly trained nurse consultant who specialises in this field.
6. The Falls prevention training day for Care Home Managers run by the West Sussex Health and Social Care Trust in November 2008 at St Richard's Hospital appears to have been effective.

Conclusions and opportunities for further development of this project

1. It is proposed to continue this project over the next two years. Working with other agencies will be key.
2. It will be useful to discuss with the Care Quality Commission what they see as the most relevant guidance and what is acceptable. We need to discuss whether there is a need for the Department of Health's "National Minimum Standards for Care Homes for Older People" to be supplemented with other guidance.
3. It would be informative to discuss with the Primary Care Trust and local NHS Trusts the detailed cost implications of these accidents.
4. Further investigation to try to establish if pressure alarm pads to alert staff to moving residents, could profitably be more widely used.
5. Discussion with the Primary Care Trust as to whether there is any value and possibility of a District specialist nurse working in the field of medication reviews in care homes.
6. Seeking to make links with those persons involved in falls prevention work at the West Sussex Health and Social Care Trust.

Report by David Gibson, Senior Environmental Health Officer, 23 April 2009

Approved by Ian Brightmore, Environmental Health Manager, 23 April 2009

References

(a) Chichester District Council Health and Safety Enforcement Service plan for 2008/9
(b) HELA LAC 67/1. Advice to local Authorities on inspection programmes and an inspection rating system (Rev3)
(c) Health and Safety in Care Homes. HSE guidance HSG220.
(d) Care Homes for Older People - National Minimum Standards. Department of Health. 2002. http://www.cqc.org.uk/
(e) "Slips, Trips and Falls". Prevention and Management in Residential and Nursing Care – A Guide to Good Practice produced by West Sussex Health Authority. 1998.