South East Coast Ambulance Service NHS
NHS Foundation Trust

Community Falls Team Procedure

Contents

1 **Scope** 2

2 **Procedure** 2

3 **Definitions** 8

4 **Responsibilities** 8

5 **Education and Training** 8

6 **Audit and Review (evaluating effectiveness)** 8

7 **Associated Trust Documentation** 9

8 **References** 9

9 **Appendix A** 11

10 **Appendix B: CFT Falls Response Flowchart** 12

11 **Appendix C: Falls PCR Document** 13

12 **Appendix D: Guidance on managing pressure areas** 14

13 **Appendix E: Equipment list** 18

14 **Financial Checkpoint** 19

15 **Equality Analysis** 19

1 Scope

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to providing high quality patient care. Some older patients who suffer falls, and who cannot get themselves up, are at risk of developing additional disease processes if they experience what is referred to as a "long lie". A long lie is a period of time sufficient to cause conditions such as dehydration, acute kidney injury, hypothermia, pressure damage (among others) despite being uninjured in the fall.

1.2. The Trust has developed a policy document which describes the model of care which this procedure operationalises.

1.3. This procedure is applicable to all staff and clinicians in the Trust who attend fallers and sets out the processes which should be followed. For the purpose of this document, the term "staff" refers to employees, volunteers, and other members of other trust approved agencies.

2 Procedure

2.1. Please refer to the Community Falls Team Model of Care Policy for the definitions and descriptions of the falls model (for example, primary, secondary, and tertiary response).

2.2. **Detection and Assessment of incidents**

2.2.1. Falls incidents will be received via the 999 (or NHS111) system(s) and be triaged and prioritised in the usual way.

2.2.2. Where a standard trust response is available at the time of call, this will be deployed in the usual way.

2.2.3. Where it is clear that a trust response is not immediately available, a Community Falls Team (CFT) response should be identified as a primary response to the fall, and the Emergency Operations Centre (EOC) clinicians should seek to provide telephone-based interventions as the primary response to the fall.

2.2.4. Regardless of the prioritisation of the call (i.e., C3 or C4), mobilisation of the **primary response** by a CFT (or EOC clinician) should seek to achieve a response to the patient within 30 minutes to apply the measures intended to reduce the risk of a long lie (comfort measures, coaching, removal from floor using lifting chair etc).

2.3. **Mobilisation of response**

2.3.1. Please refer to **Appendix A** for mobilisation flowcharts

2.4. CFT resources will be mobilised according to their type (CFR, FRS etc). Please see sub-heading below

2.5. Community First Responders (CFR)

2.5.1. CFRs will be mobilised to incidents according to the existing trust guidance when responding from home.

2.5.2. Where a CFR team has a dedicated trust vehicle and is "on duty" in this vehicle, mobilisation will be via a Trust Mobile Data Terminal (MDT). Mobilisation using own car will follow the standard CFR procedure.

2.5.3. CFRs responding from home can respond alone to apply comfort measures and/or meet another falls equipped CFR on-scene to attempt removal from floor, if applicable

2.5.4. A lone CFR may attend and be met on scene by a Fire & Rescue Service CFT or Trust responder

2.5.5. CFRs will travel to scene under normal road conditions (please refer to Driving Standards Policy)

2.6. Fire & Rescue Services

2.6.1. The Resource Dispatcher will contact the FRS for that county and request a "primary response to a faller".

2.7. Other trust approved agencies

2.7.1. At the time of publication, no other agencies are responding for the trust.

2.7.2. Additional agencies mobilisation plans will be appended to this document as they come on-line.

2.8. **Actions at scene**

2.8.1. Please refer to **Appendix B** for an overview of the model of care, including actions on scene.

2.8.2. Assessment

2.8.2.1. A standard patient assessment will be undertaken on arrival at the patient's side. This will be according to the scope of practice (i.e., CFR, IECR).

2.8.2.2. The initial assessment should be undertaken, and any immediate escalations of care made via EOC. If the patient has an obvious injury, such as limb deformity, head injury (with or without neurology), large or significant wound, or other concerning presentation, EOC must be contacted immediately to request Grade 2 back-up.

2.8.2.3. If the patient has no priority signs and symptoms, and denies new or worsening (chronic) pain, a discussion should commence with the patient about methods of trying to get off the floor.

2.8.2.4. The assessment, care and management plan should be documented by the CFT using the specified patient report form (see **Appendix C** for copy of falls PCR).

2.8.3. Comfort Measures

2.8.3.1. The CFT model is not solely a lifting service. On occasions where the patient cannot be lifted due to their injuries/pain, or insufficient resources (human, equipment) are in attendance, comfort measures should be applied.

2.8.3.2. Comfort measures are part of the falls specific training for primary responders and only elements which have been taught should be applied, particularly where patient handling is required.

2.8.3.3. Comfort measures are intended to reduce the risks associated with a long lie. Patients who remain on the floor while in the care of the CFT should receive the following comfort measures.

- Verbal reassurance
- Warming (mindful that frail older patients may become hypothermic even on relative warm day, particularly when on a cold/hard surface)
- Easing of pressure areas (see **Appendix D**)
- Hydration. Offer fluids and encourage patient to drink to thirst
- Support patients to take planned medications (CFT cannot administer parenteral medicines). Where there is any doubt or concern, an ECAL should be requested, and the care discussed with a PP.
- Prepare to support potential incontinence (reassurance, placing of pads, removing excess clothing which may cause skin damage if saturated with urine). CFT MUST NOT provide personal care.
- Consider nutrition (request urgent ECAL for patients with conditions such as Type 1 diabetes)

2.8.4. Lifting from Floor

2.8.4.1. Following assessment and applying any comfort measures necessary, attempts should be made to get the patient off the floor and back to a position of comfort and safety (i.e., chair or bed).

2.8.4.2. Initially, patients should be coached to self-mobilise. If the patient lacks the strength to do this, do not coax the patient to try harder – move to the next option using a lifting device.

2.8.4.3. Where patients need to be lifted from the floor, manual handling techniques must not be used which involve taking the patient's bodyweight.

2.8.4.4. The Raizer chair or Mangar lifting cushion should be used, along with any manual handling aids such as belts or turntables.

2.8.4.5. CFT primary responders MUST receive Trust training before using lifting devices.

2.8.4.6. If a device fails or the patient cannot be safely moved using the device, abort the procedure and gently return the patient to the floor. If you need to return the patient to the floor, consider placing a duvet or other padding under the patient if possible.

2.8.4.7. Once the patient is back in their chair or bed, reassess them and contact a PP Urgent Care Hub via ECAL to discuss the next phase of care.

2.8.5. <u>Interrupted Care</u>

2.8.6. The Model of Care does not require the primary responder to wait on scene until the secondary responder arrives if the patient is safe to be left and this has been discussed and agreed with a paramedic practitioner in an Urgent Care Hub (or equivalent senior clinician).

2.8.7. Primary responders must provide a full and accurate handover to the PP Hub including at least one set of relevant clinical observations. The PP may request additional observations (for example, a standing blood pressure) or a full second set of observations based on the history given and medicines list. Primary responders should not anticipate standing down upon commencement of the call with the Hub and work with the PP to agree the safest disposition.

2.8.8. Where it is agreed that the primary response can stand down from scene, every effort should be made to ensure that the patient is not left alone. Patients who cannot be left with a family member, friend or neighbour should be reviewed as part of the discussion with the PP Urgent Care Hub to ensure that leaving them alone while the secondary response is en-route is safe and appropriate.

2.8.9. Worsening care advice (WCA) and safety netting will form part of the discussion with the Urgent Care Hub and this information should be documented and a copy left with the patient. Patients and carers must be well informed of what to look out for in terms of potential clinical problems/deterioration and how to seek assistance in the period after the primary responder leaves.

2.9. In some cases, it may be necessary for the primary responder to wait on scene for the secondary response. In situations where the patient has an

obvious injury and/or is in acute or worsened chronic pain, the primary responder must wait on scene for the arrival of the Trust response.

2.9.1. Follow-up (secondary response)

2.9.2. Fallers attended by a primary responder should be followed by secondary response. The secondary response is a standard trust resource (SRV or DCA) which should arrive within the Ambulance Response Programme (ARP) response time for the category of call (i.e., 120 minutes for a category 3, 180 minutes for a category 4). Primary responders do not “stop the clock”.

2.9.3. Where the requirement for secondary is suggestive of a clear outcome (i.e., recent history of UTI potentially being contributory to the fall) a specific response from an operational PP should be considered. This will form part of the discussion with the Urgent Care Hub.

2.9.4. The secondary response will carry out a focused assessment of the patient according to their scope of practice. Secondary responders should review the documentation left by the primary responder and use this information as part of their assessment of the patient.

2.9.5. In the event that the secondary response identifies an injury that was not detected by the primary responder, standard clinical care should be carried out (i.e., conveyance to ED, referral to a PP for wound care or minor illness management).

2.9.6. In cases where the secondary response finds new or previously undetected illness or injury following the attendance of the primary response, this should be reported via the DATIX system. This is only to report the occurrence and must not be an inference of blame. The falls model of care will be continually reviewed and therefore information gathering on outcomes is essential. Reporting such cases is not a punitive act and promotes the Trust’s learning culture. Should a safety event occur (i.e., the secondary response finds the patient has fallen again on their arrival, this should be reported as an adverse event – see section 2.21)

2.9.7. Referral (tertiary response)

2.9.8. The secondary responder will, if the patient is not conveyed to ED or referred to a PP for further care, complete a falls referral via IBIS.

2.9.9. Where the patient is at risk of further falls or may be subject to an avoidable admission in the immediate period following the fall, the secondary responder should seek to refer the patient immediately to the most appropriate responsive community service via Service Finder.

2.10. Clinical oversight and referral management

2.11. The PP Urgent Care Hubs are responsible for providing clinical oversight and support for primary and secondary responders and should seek to optimise patient care and flow.

2.12. The Urgent Care Hubs can assist with supporting risk management decisions and signposting to community based responsive services in order to support admission avoidance.

2.13. The Urgent Care Hubs will also manage requests for PP follow up for patients with minor injuries arising from their fall.

2.14. Local falls governance meetings (falls forum)

2.15. Falls primary responders will be invited to attend regular governance sessions within their local operating unit, led by the paramedic practitioner team, supported by Practice Development Leads and operational managers.

2.16. The purpose of these “falls forums” are to:

- Create a community of practice among primary responders
- Review cases of falls incidents (learning from when things go well and when things do not go well)
- Undertake refresher training
- Discuss the evidence base and practice guidance regarding falls and frailty
- Meet with expert clinicians from the local health economy to look at falls and frailty pathways and to discuss how to optimise patient outcomes.

2.17. Falls forums should be held 3 to 4 times per year as a minimum and should include all SECAmb staff and primary responders who want to take part.

2.18. Falls forums will include discussion of real incidents, but reviews must be anonymised to ensure compliance with information governance requirement.

2.19. The local PP Team (delegated to a lead PP) and PDL will organise each forum event, produce the agenda and circulate the date, time, and location of each meeting to the local staff and primary responders. This will also include inviting external speakers/experts

2.20. Adverse events

2.21. Any adverse event regarding the falls model of care, such as falls occurring during interruptions of care must be reported via Datix.

2.22. Incidents deemed serious or significant should be escalated to the duty Tactical Commander at the time and consideration given to a discussion with the Strategic Medical Advisor on-call.

3 Definitions

3.1. Fall/faller. Low energy fall, such as those typically experienced in the home or other domiciliary setting. Excludes high energy “trauma” such as falls from height.

3.2. Please refer to the Community Falls Team Model of Care Policy for definitions of terms.

4 Responsibilities

4.1. This procedure is aligned to **Community Falls Team Model of Care Policy** which provides guidance on trust actions and intent at a policy level. This document should also be read in conjunction with the **Scope of Practice and Clinical Standards Policy** for guidance on clinical scope and authority to act.

4.2. The **Medical Director** is responsible for clinical practice and patient safety in the Trust.

4.3. The **Consultant Paramedics (urgent & emergency care)** are responsible for the Community Falls Team model of care and associated procedure.

4.4. The Emergency Operations Centre are responsible for the mobilisation of CFT resources. A nominated **Operations Manager Clinical** is responsible for this aspect of the model of care.

4.5. The **Emergency Service Collaboration Manager** is responsible for interagency liaison with fire and rescue services who respond as part of the CFT model.

4.6. **Operating Unit Managers/Operations Managers/OTLs** are responsible for supporting and promoting the effective use of the CFT model at operating unit level, including supporting the **Practice Development Leads** and **Paramedic Practitioners** with providing local falls meetings.

5 Education and Training

5.1. Please refer to the Community Falls Teams Model of Care Policy for information on standards of education and training for falls responders.

6 Audit and Review (evaluating effectiveness)

6.1. The falls model of care will be subject to audit and review following the first full year of operation, or sooner in light of any recommendations arising (i.e., following a complaint or SI).

6.2. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

6.3. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

6.4. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

6.5. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

7 Associated Trust Documentation

10.1 The Scope of Practice and Clinical Standards Policy

10.2 Health and Safety Policy and Procedure

10.3 Urgent Care Toolkit

10.4 Incident Resourcing, Deployment and Management Standing Operating Procedure

10.5 Driving Standards Policy and Procedure

10.6 Community Falls Patient Clinical Record

10.7 Community First Responder Policy

10.8 CFR Volunteer Agreement and Handbook

8 References

11.1 ISTUMBLE post falls assessment tool, originating in West Midlands Ambulance Service.

11.2 FRAT – Centre for Medicines Optimisation, Keele University.

11.3 NICE Guidance CG161 Falls in older people: Assessing Risk and Prevention.

11.4 JRCALC 2019 - Falls in older Adults.

11.5 Association of Ambulance Chief Executives (AACE) Falls Response Governance Framework for NHS Ambulance Trusts.

11.6 Falls Response Governance Framework for NHS Ambulance Trusts - aace.org.uk.

8.1. Datix Procedure: This section must include a list of all related Trust documents, for example, policies and procedures that support this document.

8.2. If it is a new procedure you are creating, ensure that there is a cross reference back to the new procedure from any document listed here.

8.3. Where possible, include a link to the relevant documents on the intranet or internet.

8.4. This section must not include any documents that are no longer available, and authors should take care to check that document titles are accurate.

9 Appendix A

999/111 call received into EOC for patient who has fallen and is on the floor

30-minutes

EOC Clinician attempts to call-back (first or second party) to assess risk factors and provide enhanced interim-care advice - *supported by EOC Clinician Fallers Flowchart.* **Can the patient be coached to self-mobile off the floor?**

Resource Dispatcher (RD) allocates nearest/suitable/available front-line A&E resource (e.g., DCA or SRV). RD to consider sending **Community Falls Team** (CFT) if available and likely to arrive before A&E resource.

Response Desk Coordinator actively screens CAD for CFT suitable cases - highlighting to RD

Yes — EOC Clinician provides primary response and coaches patient off floor.

No — RD confirms/identifies and assigns **Community Falls Team** (CFT) - e.g., CFR or Fire & Rescue

CFT provides primary response - undertakes initial assessment of patient condition and provides immediate care to reduce risks

1-hour

No — EOC Clinician refers patient to appropriate local service (e.g., primary or community care) to provide secondary response

Yes — EOC Clinician contacts Resource Dispatcher to advise the patient is off floor, however a response is still required – *advising on preferred type of resource and clinical grade*

Resource Dispatcher (RD) allocates nearest/suitable/available front-line A&E resource to provide secondary response

CFT contacts Response Desk in EOC to request a clinical call-back via Emergency Crew Advice Line (ECAL)

PP within Urgent Care Hub calls CFT to discuss the patient's condition and collaboratively agree plan. **Is it safe (and is the CFT equipped) to assist the patient off the floor?**

No — PP (Urgent Care Hub) contacts Resource Dispatcher to advise back-up is required for CFT on scene – *advising on preferred type of resource and clinical grade.*

Yes — CFT assists patient off floor, completes documentation and stands down. Case remains active on CAD with original disposition. PP contacts RD to update.

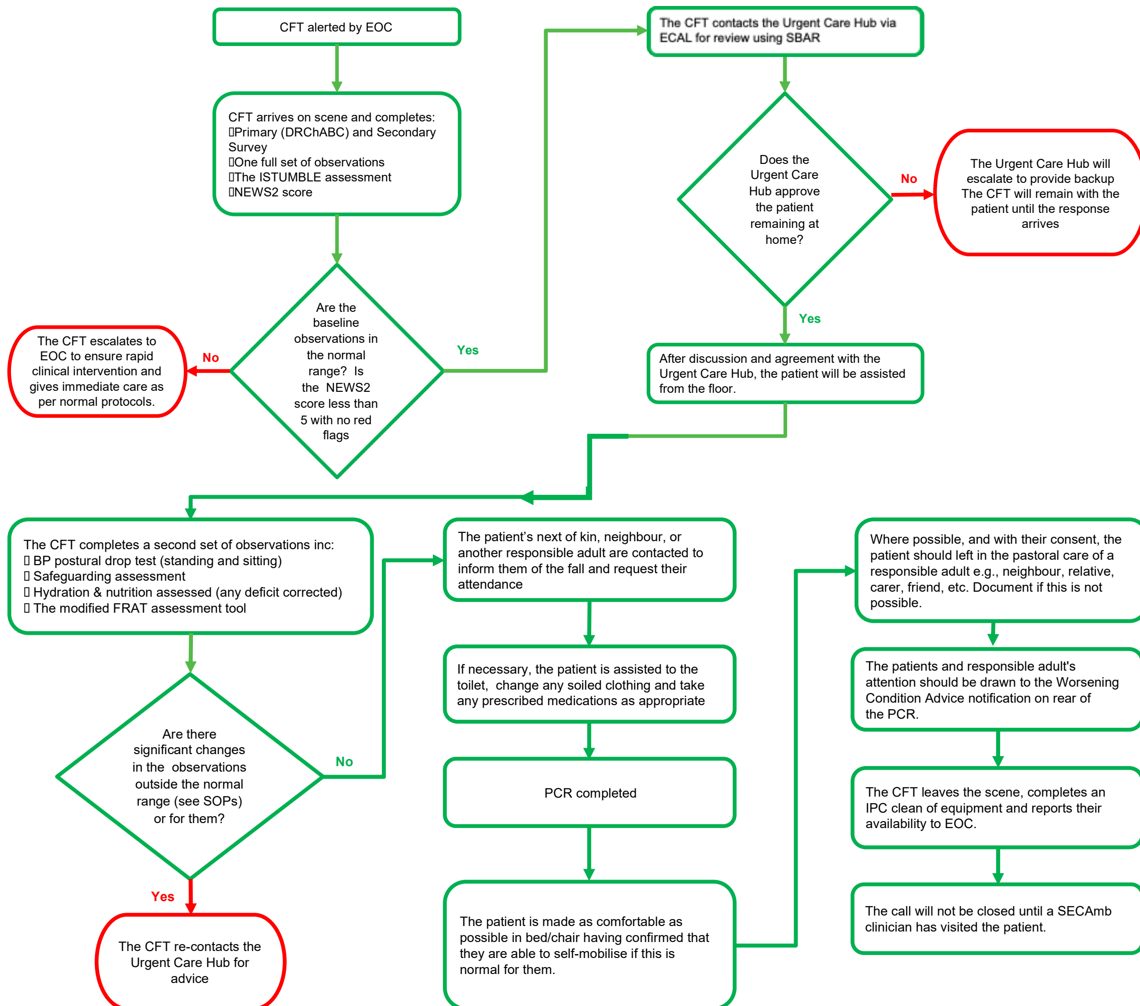
Interrupted

Following full assessment and treatment – Clinician completes episode of care and notifies/refers to tertiary response for follow-up, wholistic review and input

Conveyance

South East Coast Ambulance Service NHS
NHS Foundation Trust

10 Appendix B: CFT Falls Response Flowchart



South East Coast Ambulance Service NHS
NHS Foundation Trust

11 Appendix C: Falls PCR Document

F 00001

Complete boxes in black ink & BLOCK CAPITALS. Do not strike through blank sections.

Community Falls Team PCR

Incident Date / / — Incident Number

Call Sign Letter — Call Sign Number — Base OU Talk Group

ID Personnel Number — Grade — Call Time

1 2 3 4 5 6

At Scene — At Patient — Left Scene

Location of Incident — As Patient Address

Patient Unwilling / Unable to Provide Details

DNACPR/ RESPECT

Rockwood Frailty Score

First Name

Surname

D.o.B — Age — D/W/M/Y

Gender M/F/U/O — Ethnic Code — NHS Number

Patient Address

Tel: — Postcode

GP Name & Address

Next of Kin (Name, Relationship & Tel.)

Mental Capacity Concern Y N — Communication Difficulties

Safeguarding Concern Y N — Learning Disability — Physical Disability

Presenting Complaint — Onset of Symptoms — Symptom Onset Over 24hr

Primary Survey

Consent Y N — Catastrophic Haemorrhage Y N

Airway: Clear — Obstruction

Breathing: Present — Ineffective — Absent

Circulation: Peripheral — Central Only — Absent

Alertness: A C V P U

Spinal Immobilisation: Yes — Not Req — Refused

FAST positive?: Face Y N UTA L R — Arm Y N UTA — Speech Y N UTA

Observations

Time — Resps — SPO2 (%) — On Air — On O_2 — Peak Flow — Heart Rate — Systolic BP — Diastolic BP — Temp — Blood Glucose — Pupil Size (mm) L R — Pupil Reaction L R

S=Slow N=Normal F=Fixed U=Unable to Assess

Pain Score — NEWS 2 — Capillary Refill (Sec)

HPC - what were they doing before fall, how did they fall, raise the alarm?

PMH

Patient Assessment: SHx, Meds, Allergies, OA, OE, Tx, Plan, Any other useful information

No. of Continuation Sheet(s)

Drugs (including gases)

Drug/Gas Name — Code — ID — Time — Dose / % — Unit — Route — Batch — Expiry

Airway Management — Effective — ID

Manual — Size — OPA / NPA

Cardiac Arrest

Time CPR Started — Total No. Shocks — Time 1st Shock — Signs of Life at Any Time

ISTUMBLE assessment

I = Intense pain

Is there any new pain since falling e.g headache, chest pain abdo pain? Y N

Is there any pain from injury caused by fall or medical cause? Y N

S = Suspected collapse

Did they collapse? Y N

Did they feel dizzy or do they now? Y N

Did they feel nauseous or do they now? Y N

T = Trauma to neck / back / head

Is there new pain in neck, back, head following fall? Y N

Are there any lumps or dents in head with / without bleeding? Y N

Is there any new numbness / paralysis in any limbs? Y N

Do they take any blood thinning medication e.g Warfarin, Rivaroxaban? Y N

U = Unusual behaviour

Is there any new confusion? Y N

Are they acting differently to normal e.g agitated, drowsy, quiet? Y N

Do they have any new difficulty in speaking e.g slurred speech, words mixed up, marked stuttering? Y N

M = Marked difficulty in breathing / chest pain

Is there any severe shortness of breath, not improved when anxiety is reduced? Y N

Are they unable to complete a sentence? Y N

Are their lips or finger tips blue or pale? Y N

Are they becoming lethargic or confused? Y N

B = Bleeding freely

Is any blood free flowing, pumping or squirting from a wound? Y N — Stop bleeding, estimate the blood loss (record in text box)

L = Loss of consciousness

Was there any loss of consciousness? Y N

Are they drifting in and out of consciousness? Y N

Do they have limited memory of event before, during or after fall? Y N

Are they able to retain or recall information and repeat it? Y N

E = Evidence of Fracture

Is there any deformity to limbs e.g shortening, rotation, bone visible, severe swelling? Y N

Is there any new reduced range of movement? Y N

Is there any unusual movement around the affected area? Y N

What resources were used in moving the patient?

Mangar Elk — Raizer Chair — Turntable — Slide Sheet — Banana Board — Manual Handling Belt

What response was there to moving the patient?

Any onset of new pain? Y N

If so, where?

Any incontinence? Y N

Can the patient mobilise as before? Y N

If not, what has changed?

If unable to lift the patient what action was taken?

Made comfortable and warm? Y N

Relief of pressure areas? Y N

Other?

Other actions

Any fluids or food given? Y N

Assisted to the toilet? Y N

Made comfortable and settled? Y N

Assisted to take own medication? Y N

Other?

Urgent Care Hub's Clinical Decision

Time Urgent Care Hub Contacted

Name of Urgent Care Hub HCP

Was agreement reached to assist the patient from the floor? Y N — Time

Was the patient left in the care of a responsible adult? Y N — Time

Was their attention drawn to the Worsening Care Advice? Y N

Did the patient refuse any further SECAmb interventions (attendance)? If yes, a DIP-1 report must be completed via the Operational Support Desk (03001239199) Y N

Falls Risk Assessment Tool "FRAT" (Modified)

Has the patient had a fall in the past 12 months? Y N

Are they on 4 or more medications? Y N

Do they have Parkinson's / have they had a stroke? Y N

Do they feel unsteady / have problems with balance? Y N

Can they complete the "Timed up and Go" test? Y N — Stand up from the chair, walk 3 metres at their normal pace, turn, return to the chair, sit down

Do they struggle to get up from a chair? Y N

Responder Name/Signature — Form Completed By ID

RIC/20190429/PCRV4.1

12 Appendix D: Guidance on managing pressure areas

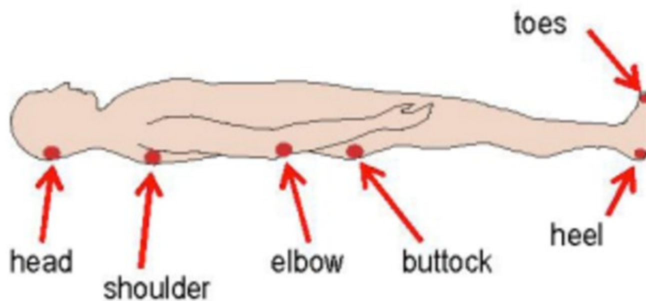
The following is taken from the NHS "Stop the Pressure" website - https://nhs.stopthepressure.co.uk/patients.html

A pressure ulcer is damage that occurs on the skin and underlying tissue. Pressure ulcers are caused by three main things:

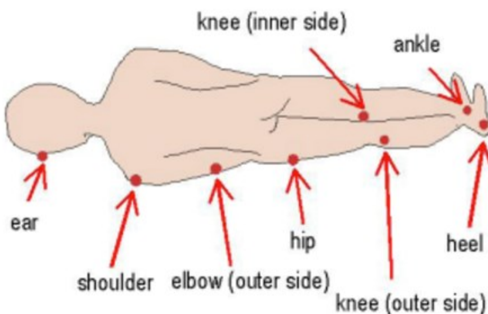
- **Pressure** - the weight of the body pressing down on the skin
- **Shear** - the layers of the skin are forced to slide over one another or over deeper tissues for example when you slide down or are pulled up, a bed chair or when you are transferring to and from your wheelchair.
- **Friction** - rubbing the skin

The most common places for pressure ulcers to develop are over bony prominences (bones close to the skin). Some of the most common sites are shown below:

Body lying flat on back



Body lying on side



Person sitting up in bed

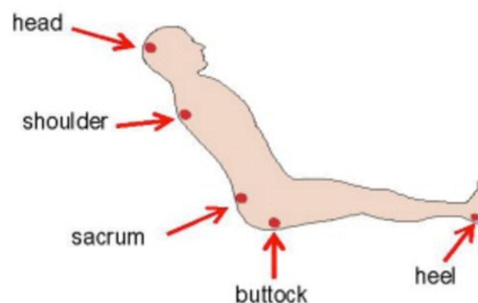


Illustration kindly used with permission of Family and Elderly Health Services, Department of Health, Hong Kong.

Note:

Pressure ulcers can develop from external medical devices too such as oxygen masks, casts, catheter tubes, splints, footwear and glasses.

What are the signs to look for?

The first sign that a pressure ulcer may be forming is usually discoloured skin, which may get progressively worse and eventually lead to an open wound.

- On light - skinned people, red patches of skin that do not go away.
- On dark - skinned people, bluish/purplish patches that do not go away
- Blisters, or damage to the skin
- Patches of hot skin
- Swelling
- Patches of hard skin
- Patches of cool skin

Who is at risk?

Anyone can get a pressure ulcer, but some people are more likely to develop one than others. People with a pressure ulcer are also at risk of developing another elsewhere on their body.

You are more at risk of getting a pressure ulcer if you:

- Have problems moving and cannot change position by yourself without help
- Cannot feel pain over a part or all of your body
- Are incontinent
- Are seriously ill or undergoing surgery
- Have had pressure ulcers in the past
- Have a poor diet and don't drink enough water
- Are very old or very young
- Have damaged your spinal cord and can neither move nor feel your bottom and legs
- Have heart problems or poor circulation

How to prevent pressure ulcers developing

Pressure ulcers can develop very quickly in some people if the person is unable to move for even a very short time – sometimes within an hour.

Keep Moving

One of the best ways of preventing a pressure ulcer is to reduce or relieve pressure on areas that are vulnerable to damage (see diagrams on page 2). This is done by moving around and changing position as much as possible.

If possible, change your position at least every two hours; alternate between your back and sides. **If you already have a pressure ulcer, lying or sitting on the ulcer should be avoided as it will make the ulcer worse.** People with limited mobility may need to have assistance to change their position by a healthcare professional or a carer.

Use pillows to lift your heels off the bed, or to stop your ankles and knees touching each other especially when you are lying on your side. Image shown is of a lower leg

elevated on a pillow to suspend the heel and relieve pressure. The pillow is placed lengthways and extends from the back of the knee to the back of the ankle.

Shared with permission from The Dudley Group Foundation Trust

You may need a special mattress, or seat cushion. Your healthcare professional can advise you on what will be suitable for your needs.

Skin Assessment

Your skin should be assessed regularly to check for signs of pressure ulcer development. How often your skin is checked depends on your level of risk and your general health. You or your carer should inspect your own skin for signs of pressure damage – you may need help to look at awkward areas such as your bottom or heels.

A good diet

Eating well and drinking enough water is very important. It is particularly important for people at risk of developing a pressure ulcer or those with a pressure ulcer. If you already have an ulcer your body will require extra calories to heal. Eating foods high in calories and protein – such as cheese, fish, meat and eggs – can help.

If you do have a pressure ulcer, your healthcare professional may refer you to a dietician for specialist advice.

Incontinence/moisture

Urine, faeces and sweat can cause skin damage. It is essential to keep skin clean and dry. Ensure you follow these principles:

Frequent toileting

If you require a continence product, ensure they are fitted by a health care professional

Wash your skin with non-perfumed soap, preferably pH balanced, pat skin dry. You may require a barrier product to protect your skin.

Avoid oil-based creams such as Sudocrem, Metanium or Conotrane if you wear continence products as they can affect absorbency of the product

Who do you contact for advice / help?

If you or your carers notice possible signs of damage you should tell a healthcare professional immediately.

There are examples of patient's stories and their experience under the resources section

Further information is available through:

Pressure Ulcer Research Service User Network (PURSUN)

PURSUN UK was set up to improve the quality of Patient and Public Involvement in pressure ulcer research. We are a network of service users, patients and carers who work to ensure that pressure ulcer research is relevant to the public and is carried out in an ethical and respectful way.

Click on this link: http://medhealth.leeds.ac.uk/pursun/#

Your Turn

The Your Turn Campaign aims to prevent pressure ulcers through education. We help people understand who is at risk, and what they can do to avoid getting a pressure ulcer.

Click on this link: http://www.your-turn.org.uk/

13 Appendix E: Equipment list

The Community Falls Team (CFT) will consist of either experienced Community First Responders (CFRs) or Firefighters (FF) that will undergo additional training to respond to those patients that are at risk of an elongated time on the floor following a fall.

Items marked with an Asterisk are those already carried by CFRs or by Fire and Rescue Services.

- Primary Response Bag x1 *
- AED x1*
- IPC Red Bag
- Hand Gel x 1
- Gloves x 1 box per size
- 1 roll of Aprons
- Fluid Repellent Face Masks 1 box
- Raiser Chair/Mangar Elk
- Patient Positioning Belt x 1
- Turntable x 1
- Disposable Slide Sheets x10
- Inco Pads x10
- Clinell Wipes x1 pack
- Patient Clinical Records x 1 Pad

14 Financial Checkpoint

14.1. This document has been confirmed by Finance to have no unbudgeted financial implications.

15 Equality Analysis

15.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

15.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.