Gwent Integrated Falls Service

Dr S Vasishta
ABHB Clinical Lead for Falls Service
An unwanted event whereby an individual comes to rest inadvertently either on the ground or another level from standing height, without loss of consciousness – NICE CG 21 (2004)

“Symptom of Frailty”
Falls are significant events in an older person’s life. They increase with age and frailty. They increase injuries, fractures, and mortality. They increase ambulance call outs and conveyances. They increase hospital admissions and length of stay. They increase disability, reduce independence, and QOL. They lead to an increase in institutional care. They are costly.
Falls generally occur because of an interaction between “intrinsic” and “extrinsic” risk factors.

The more the risk factors, the higher the risk –

- 8% in older adults with no risk
- 78% in older adults with 4 or more risk factors

(Tinetti, 2003)
Burden on health care resources

Mean LOS all ages 7.9 days
Mean LOS # femur 25.7 days
Mean LOS falls 9.67 days
GUIDELINES AND STANDARDS

- National Service Framework Wales – Std 8 (Falls and Fractures)
- NICE - CG21 Falls - The Assessment and Prevention of Falls in Older people
- Living Well – Ageing Better
- National Patient Safety Agency 2007
- National Osteoporosis Guidelines (NOGG) 2011
- 1000 Lives Campaign
- RCP - Falls & Bone Health Audits 2007, 2009, 2010
- Doing well, doing better: Standards for Health Services in Wales
- Care and Social Services Inspectorate Wales (CSSIW)
- National Institute for Clinical Excellence – CG 56 Head Injury
GUIDELINES & NATIONAL STANDARDS

STANDARD EIGHT for Falls (Key interventions): – The standards set out key changes needed to reduce the number of falls and their impact through –

- Falls prevention
- Prevention and treatment of osteoporosis
- Improving the care and treatment of those who have fallen
NICE Guidelines

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment.

- To be performed by healthcare professionals with appropriate skills and experience normally in the setting of a specialist falls service.

- This assessment should be part of an individualized, multifactorial intervention.
NICE – Multi-factorial assessment

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness
- Assessment of the older person’s perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment
- Assessment of urinary incontinence
- Assessment of home hazards
- Assessment of osteoporosis risk
- Cardiovascular risk and medication review
Evidence for falls prevention interventions?

There is a strong evidence base of more than 60 randomised controlled trials of interventions to prevent falling. The evidence shows that risk assessment and multifactorial intervention programmes can achieve a substantial reduction (6-30%) in the incidence of falls among older people.


Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2009
Gwent Falls Strategy

Based on extrapolation from epidemiological studies and data from Public Health Sources, Gwent can expect to have 33,400 residents (35% of the total 95,440 residents over the age of 65) at risk of falls, who would benefit from local fall services.

Population statistics by local authority areas (LAA) – 4060 (Blaina Gwent), 5240 (Monmouth), 5380 (Torfaen), 8400 (Newport), 10,300 (Caerphilly)

The Falls Strategy includes people living in the Community, care homes, hospital and other settings.
AMBULANCE DATA FOR ABHB FALLERS 2012

![Graph showing the number of attendances and conveyed cases across different months in 2012. The graph compares the attendances (blue line) and conveyed cases (red line).]
Gwent Falls (Frailty) Strategy

Historic dates -

- November 2009 - Baseline existing falls services. Explore the possibility of a Pan Gwent approach to falls with partners
- September 2010 – Key Falls work streams identified
- April 2011 - Falls to be incorporated into Frailty. Localities FIG asked to identify their workforce
- June 2011 – Falls strategy and model approved by the Frailty Board
- December 2011 – Falls steering group – subgroup leads allocated
Gwent Falls (Frailty) Strategy

Frailty Service –
- Rapid response Nursing
- Rapid response Medical
- Urgent social care
- Reablement
- Falls assessment and management service

Aim –
- Prevent unnecessary hospital admissions
- Support timely discharge
Gwent Falls (Frailty) Strategy

In September 2010, a pan Gwent workshop identified key falls work streams which are now nearing completion –

- WAST pathway
- Accident and Emergency pathway
- Community pathway (current / historic faller)
- Care homes (current / historic / post fall management)
- Frailty Community Resource Team (CRT) / Falls Service
- Falls service monitoring

- In patient fallers (separate subgroup)
Gwent Falls (Frailty) – Care Model

Builds on the existing falls services in Gwent with some redesign to try and standardise approach and realign with frailty

Services to be integrated into a co-ordinated, cohesive and comprehensive falls service - encompassing population level health promotion and, for selected groups of individuals, screening, assessment and treatment

The service to be delivered through a four tier integrated rehabilitative care pathway model moving individuals along the care tiers wherever possible
GENERAL FALLS ASSESSMENT MODEL

TIER 1
General Health Promotion
Falls Prevention Awareness and Information
Patient Identification

TIER 2
Falls risk screening with FROP Com Screen
Faller referred to CRT via SPA

TIER 3
Community (CRT) / Clinic based Specialist Falls Service including medical assessment / Specialist Falls Balance and Gait programme

TIER 4
CONSULTANT LED SPECIALIST BALANCE CLINIC
Complex balance / dizziness problem

If – Complex needs identified
Significant gait & balance problem
Unexplained falls or falls related to dizziness / blackouts
Second opinion requested by patient / carer / GP

CRT contact, consent, assess with FROP CoM Tool (Assessment tool). Develop action plan. CRT Falls MDT to agree interventions / referrals. Inform GP of outcomes.

Discharge patient or step to Tier 3

CRT – Community Resource Team
SPA – Single Point of Access
FROP CoM – Falls Risk for Older People (Community)
MFFRAT – Multifactorial Falls Risk Assessment Tool
Reducing Harm from Falls
Driver Diagram

**Content Area**

**Drivers**

**Interventions**

To reduce the mortality and harm from falls that occur in the community

- **Trigger Bundle**
  - The falls event will be logged and initial screening completed within 24hrs

- **Assessment Bundle**
  - Basic multifactorial risk assessment is completed within 7 days

- **Intervention Bundle**
  - An agreed multifactorial plan of specialist assessment and intervention is in place and in progress within a maximum of 6 weeks

- **Monitoring Bundle**
  - Progress against the plan is monitored within 6 months

1. Complete the initial screening using an agreed tool
2. Log the fall on falls register
3. Notification of the fall as per locally agreed pathway, copy to GP

1. Take falls history
2. Complete a basic falls risk assessment using an agreed risk assessment tool
3. Provide written and verbal information about falls prevention
4. Make appropriate referrals for specialist assessment and intervention based on the outcome of the risk assessment

1. Initiate a bespoke plan for each patient, dependant on need
2. Agree the plan with the person and / or their family or carers
3. Agree time scales and a review date
4. Copy of the plan to go to the GP

1. Review compliance with the plan
2. Evaluate the efficacy of the plan in terms of further falls or injury
3. Update or close the plan as appropriate and update the falls register
GENERAL FALLS ASSESSMENT MODEL

TIER 1
- General Health Promotion
- Falls Prevention Awareness and Information
- Patient Identification
- Falls risk screening with FROP CoM Screen

TIER 2
- Faller referred to CRT via SPA
- CRT contact, consent, assess with FROP CoM Tool (Assessment tool). Develop action plan. CRT Falls MDT to agree interventions / referrals. Inform GP of outcomes.

TIER 3
- Community (CRT) / Clinic based Specialist Falls Service including medical assessment / Specialist Falls Balance and Gait programme
- If – Complex needs identified
  - Significant gait & balance problem
  - Unexplained falls or falls related to dizziness / blackouts
  - Second opinion requested by patient / carer / GP

TIER 4
- CONSULTANT LED SPECIALIST BALANCE CLINIC
- Complex balance / dizziness problem

Discharge patient or step to Tier 3

MONITOR

CRT – Community Resource Team
SPA – Single Point of Access
FROP CoM – Falls Risk for Older People (Community)
MFFRAT – Multifactorial Falls Risk Assessment Tool
Current position and the future

Agreed elements to the falls model -
- The Model itself
- Falls prevention and information
- Community non current faller pathway
- Community current faller pathway
- Care home non current faller pathway
- Care home current faller pathway
- Care home post falls pathway
- Accident and Emergency pathway
- WAST pathway
- Tier 1 Falls risk stratification screen – FROPCoM Screen
- Tier 2 Falls risk stratification tool – FROPCoM Tool
- Action plan
COMMUNITY NON CURRENT FALLER PATHWAY

NON CURRENT FALLER PRESENTING TO HEALTH / SOCIAL CARE IN THE COMMUNITY (Not in Residential or Nursing Homes)

FROPCom Screen for initial Falls risk Stratification

LOW RISK (1-3)
- Lifestyle advise - Staying Steady & Home Safety Checker (Age UK)
- Community based exercise programmes ie Extend / NERS

HIGH RISK (4-9)
- SPA
- CRT to triage
- Full Falls Assessment

GP to be informed of outcomes
**COMMUNITY CURRENT FALLER PATHWAY**

**COMMUNITY CURRENT FALLER**

- **Major injury / acute illness / head neck injury**
  - Ambulance
  - Initial Management
  - Ambulance / Frailty Falls protocol
  - Hospital
  - Follow A&E MAU pathway

- **Minor / no apparent injury**
  - General public
    - Presents to A&E
    - No further action
    - Further action
      - Inform GP / GP decide onward action
  - RH / NH
    - GP to decide on usual care

**SPA**

- CRT to Triage
- Initial event management
- Complete Falls Assessment

**GP to be informed of outcomes following Ambulance attendance**
Prior to admission assume resident at risk of falls

Familiarise resident with surroundings within 24 hours

Ensure adequate level of monitoring
Check aids and toilets signposted etc

Falls risk assessment to be completed within 24 – 48 hrs

Develop individual care plan with resident / family

Communicate care plan to all staff members

Highlight modifiable risk factors to GP

GP to assess with a view to specialist intervention

GP to refer to Falls service via SPA

GP to consider bone protection

Follow SPA – CRT pathway
CARE HOME CURRENT FALLER PATHWAY

Residence has fallen OR found on floor

Call for assistance, Reassure, Assess residents responsiveness and injury (top to toe survey)

Major injury / acute illness

- 999
- Do not move
- First aid if needed
- Keep warm
- Observe

Ambulance to assess & decide if transfer to hospital required

Major injury / acute illness

- Hospital
- Not transferred

Follow A&E MAU pathway

No worrying features

Minor / no apparent injury

- Assess safe move
- First aid if needed
- Treat minor injury

Observations for 24 – 48 hours for worrying features / change in condition

GP to be informed of outcomes following Ambulance attendance or by care home if minor injury

Worrying features

Refer to CG56: head injury guidelines

Head / neck injury (Witnessed or suspected)
CARE HOME POST FALLS ALGORITHM

Notify next of kin, record details in accident book and residents notes / care plan, Notify GP
Communicate actions to staff to reduce further risk

Management - Complete reporting & investigate

Complete incidence reports Notify CSSIW / RIDDOR
Log event in Falls Register
Develop care home environmental action plan using incident findings

Environmental cause / risk

Personal cause / risk
- Review circumstances and consequences of fall
- Review residents falls risk and environmental risk within 24 hours of fall

Initiate interventions for Modifiable risk factors
Communicate risk and actions required to reduce risk
Monitor and review care plan Monthly / discuss with GP

Review circumstances and consequences of fall
Review residents falls risk and environmental risk within 24 hours of fall
Initiate interventions for Modifiable risk factors
Communicate risk and actions required to reduce risk
Monitor and review care plan Monthly / discuss with GP
Faller attends A&E

Health and Injury Assessment and intervention

- Needs admission
  - Admit Ortho/Medicine
  - Rehabilitation
  - If at discharge Frailty follow up needed

- Can be discharged with CRT support
  - SPA
  - CRT to Triage
  - Complete Falls Assessment

- Can be discharged
  - FROPCom Screen

- LOW RISK (1-3)
  - Lifestyle advise - Staying Steady & Home Safety Checker (Age UK)

- HIGH RISK (4-9)
  - Community based Exercise Programmes i.e Extend / NERS
  - Discharge

GP to be informed of outcomes at discharge
Referrals from health and Social care professionals (A&E, Hospital, Ambulance, GP etc) to Single Point of access (SPA)

Community Resource Team

Urgent response

Elective response

Primary Medical need

Rapid response

CRT Falls / Reablement (Tier 2/3)

Tier 3 Medical assessment

Comprehensive Falls assessment and intervention

Review / Evaluation / Discharge / Follow up / Monitor

GP to be notified of all actions / outcomes
MONITORING / REVIEW PATHWAY

Review

For CRT:
telephone review by HCA

For physiotherapy:
Physiotherapy service to review

Review patient’s compliance with falls intervention plan

Evaluate efficacy of plan for further falls / injury

Update plan

Close plan

Send update to GP

Update Falls 1000 lives + database

Notify Falls coordinator for update of Falls register

All reviews should include agreed Frailty Falls evaluation questions
Frailty (CRT)

A. Referrals to be made from the community via the SPA for CRT for initial logging, assessment and management if appropriate.

B. Once situation is stable a multi-factorial assessment (Risk Assessment and multi-factorial intervention tool aligned with care bundles) will be undertaken if appropriate.
Falls clinics

Previous Consultant led Falls Clinics were in existence in different localities.

Referrals are currently received by falls clinics and CRT. The pathway aims to align all referrals for tier 2 and 3 clinics via Frailty to enable referrals to be triaged in line with the Frailty philosophy.

Over time it is anticipated that the demand will increase within the CRT and resources will need to be redirected/allocated accordingly, echoing the core Concept of Frailty which promotes a shift of resources from secondary to community based care.
Care Homes

Work is underway under the Frailty Care Homes Subgroup –
A) To develop guidance and education programme for care home staff

B) To standardise the approach to falls risk assessment –
- Recommending that all residents are risk assessed at point of admission to the Care home (identify / risk assess and proactively plan prevention)
- Immediate actions to take in the event of a fall
- Actions and care plans to be revisited post fall to prevent further falls
- Care home Falls register
Other work

Work has also commenced looking at those requiring frequent admissions with data indicating falls as the highest reason for repeat admissions.

Further work is underway at locality NCN levels to align aspects of this work and clarify interfaces between the Frequent admissions coordinator, and Falls coordinator / Falls service.
Measuring efficacy of interventions, monitoring and Outcome Measures

The Frailty Falls Strategy outlines the following outcomes:

- Reduction in falls and associated injuries and fractures
- Reduction in ambulance conveyance to A&E for falls
- Reduction in the number of falls related admissions
- Reduction in subsequent falls in an year
- Effective medication reviews
- Increase in/more effective use of telecare/telehealth
- Patient experience and well-being

Delivery of the 1000 Lives Plus Interventions will be monitored using the All Wales methodology
Outcomes

- It is anticipated that the falls prevention and treatment service will make a significant contribution to the objectives of the Frailty Programme through improved quality of life for frail residents and reducing acute, community health and social care costs.

- Work has commenced and is under further development to capture falls referrals via the Frailty portal.
Achievements

- Model agreed
- Pathways completed
- Guidance for care homes being circulated – CSSIW engaged and waiting for sign off
- Care home resource pack done
- Pathways being shared with LMC
- Work awaiting to be signed off by Frailty OCG
- WAST – MOU being finalised for non urgent fallers – pilot to commence in March 13
- Frailty CRT’s at different level of implementation
- In patient steering group being restructured
Thank you!