Falls and Bone Health Programme
Unscheduled Care to Primary Care Pathway

Amanda Ryan
Falls and Bone Health Programme Manager

Wendy Hopkins
Consultant Nurse for Unscheduled Care

1000 Lives Learning Set
March 7th, 2012
Situation

• Falls and Bone Health Programme Cardiff and the Vale Health and Social Care Community

• Remit of service improvement and partnership working (Statutory and Third Sector)

• Sits under the Integrated Health and Social Care Programme Board
Situation

- RBA process, headline indicators:
  - patients treated for #NoF
  - patients treated for osteoporosis
  - emergency calls for falls
  - attendance at USC following a fall
Background - data

Stats for 2010:

• 3723 fall attendances to UHW and Barry
  • 3452 to UHW EU
  • 271 to Barry MIU
• 530 repeat fallers to UHW and Barry
• 30% repeat fallers return within a week
• many return more than once (max was 8 falls related returns for one person)
Fall Rates

Absolute numbers
corrected for population

Dickens/Johansen et al, accepted 2010
1 in 3 people over 65 fall p.a.

- Cardiff & Vale population (2001 census) = 64,500 ≥ 65

- apply annual “fallers” figure of 30%
  - [NB not falls rate which is higher].

- this gives an estimated number of fallers = 20,000.

- Cost of falls related #s for Cardiff Health & Social Care £10-12 million (primarily hip # costs)
IV: The four key aims and how we achieve them (at local level)

Objective 1: Improve outcomes and improve efficiency of care after hip fractures – by following the 6 "Blue Book" standards\(^2\)

Objective 2: Respond to the first fracture, prevent the second – through Fracture Liaison Services\(^3\) in acute and primary

Objective 3: Early intervention to restore independence – through falls care pathway linking acute and urgent care services to secondary falls prevention

Objective 4: Prevent frailty, preserve bone health, reduce accidents – through preserving physical activity, healthy lifestyles and reducing environmental hazards

15 May 2009
**Background – RCP Recs**

- **RCP National Falls and Bone Health Audit Recommendations:**
  - Improved screening and assessment of patients attending Unscheduled Care following a fall
  - Information available and given to patients following a fall
Background – Primary Care

- Consultant with Clinical Lead presented to GP Community Directors March 24th 2010
- Agreed approach to be that of Primary Care “owning” falls
- Referrals to Day Hospitals/Secondary Care only for highest risk
FALLS PATHWAY FOR PATIENTS NOT REQUIRING HOSPITAL ADMISSION

PATIENT FALLS

COMMUNITY ALARM (Cardiff Only)
- Patient Assessed/Reassured and Notified that a fax will be sent to their GP with details of their fall

WELSH AMBULANCE SERVICE
- Patient Assessed/Reassured and Notified that their GP will be notified of their fall via the Communication Hub

UNSCHEDULED CARE (EU/MIU/MEAU)
- Patient Assessed/Reassured and Notified that a fax will be sent to their GP with details of their fall

PATIENT SCREENED USING FROP-COM (i)
- LOW RISK (1-3) - leaflets given, advised home safety check, advise therapeutic exercise, GP advised of actions taken
- HIGHER RISK (4-9) - leaflets given, advised home safety check, advised of need for further assessment by GP*

COMMUNICATIONS HUB NOTIFIED OF PATIENT WHO HAS FALLEN

GP PRACTICE

GP TO UNDERTAKE FROP-COM SCREENING (i)
- (recommended within 24hrs of fall)

LOW RISK SCORE (1-3)
- Verbal advice on falls prevention
- Provides Patient with ‘Staying Steady’/Care and Repair Leaflets (b)
- Advises completion of ‘Home Safety Checker’ (c)
- Encourages Therapeutic Exercise in Community (e.g. Extend Classes) (d)
- Refers to Exercise Referral Scheme

HIGHER RISK SCORE (4-9)*
- Undertakes ‘FALLS AND BONE HEALTH ASSESSMENTS’ (recommended with 7 days of fall) (e)
- Reinforce verbal advice on falls prevention
- Check Patient has been given ‘Staying Steady’/Care and Repair Leaflets (b)
- Reinforce advice re ‘Home Safety Checker’ (c)
- Risk Score 4-5: Suggests referral to Out Physiotherapy/Exercise Referral Scheme
- Risk Score 6-7: Suggests Community Physiotherapy
- Risk Score 8-9: Suggests referral to ECAS/Day Hospital/Community Resource Team (where available)
Assessment

- USC High Demand Environments
- Increased Patient handovers
- EU Patient streams
- Medical Staff rotations
- IT Systems
- Competing priorities
- Falls Risk
- Determine Outcome, Admission v Discharge
- Communication
Assessment

Opportunities:

• Engage Clinicians (Drs, ENPs, AHPs, GPs, WAST)
• USC and Primary Care Partnership working
• Link Inpatient ‘Falls’ with Discharge work
• Improve Discharge Planning
• Influence Consistent CRT development
• Consider safe discharge for non C&V patients
• Reduce USC readmission rates
• Improve morbidity and mortality
The above named patient presented to Unscheduled Care at ............... with a fall on ...... /...... ...... 

The falls screening tool (Frop-Com Screen) was completed for this patient and scores were:

<table>
<thead>
<tr>
<th>Falls history</th>
<th>ADL status</th>
<th>Balance</th>
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<tr>
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</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2</td>
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</tbody>
</table>

Total Score.../ 9

Grading of falls risk  Low / High

Initial assessment findings (include history of fall)

Unscheduled care referrals made to prevent hospital admission

☐ USC Physiotherapy
☐ USC Occupational therapy
☐ ART
☐ Age concern HDS
☐ ECAS
☐ Community Resource Team/Service
☐ Other
☐ None required to avoid admission

Recommendations / actions from Unscheduled Care multidisciplinary team

☐ High score (4-9): recommendation that the Falls and Bone Health Assessment is completed within 7 days in Primary Care
☐ Patient has been provided with written & verbal falls prevention information
☐ Form faxed to Communications-Hub. Fax number: 01446 746837

Signed........................ Designation........................ Date
Case Study 1

- 82 Year Male
- Injury right shoulder (Dominant Hand)
- Lives alone
- Daughter main support
- IDDM
- Poly pharmacy
- Cause of fall – hypoglycaemic episode
- X-ray – no # - Sprain
- Falls risk 7/9
- GP review medication, diabetes and falls clinic
Case Study 2

- 85 year female
- Fall – 5 hours on floor – loose toilet seat
- 999
- Head Injury / CDU / Observation 24 hrs
- Safe discharge with son
- OT Assessment on day of discharge
- Falls assessment 6/9
- ECAS – Rapid response provided
Change Management

• Falls Risk Screening Flowchart for use in the Unscheduled Care Directorate – Trigger Bundle tool
• MDT Education Sessions
• User Friendly Documentation
• Staff Resource ‘Red Files’
• Consistent Referral Process
• Visual Display Board
• USC Newsletter
• Falls Link Nurses across three sites / 7 sub departments
• Review of cases, learning outcomes feedback
Assessment - referrals

- 64 Welsh Ambulance Service Trust referrals
- 68 Unscheduled Care referrals
- Referred to Primary Care GP practices via the Communications Hub
Recommendations

- Evaluate Primary Care engagement with pathway
- Demonstrate compliance with the trigger bundle in USC
- Evaluate repeat attendance at USC with a fall
- Evaluate WAST call outs and referrals
- Link to emerging FOPAL service
Thank you

Our contact details are:

Amanda.Ryan@wales.nhs.uk
Wendy.Hopkins2@wales.nhs.uk