Hereford Hospitals NHS
NHS Trust

Herefordshire NHS
Primary Care Trust

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Integrated Falls Prevention and Management Strategy for Herefordshire 2009-2014

This strategy has been developed by the Falls Strategy Working Group and membership includes the followings:

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Peter Sowerby	Impact Officer - Older People
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Executive Summary

Falls are among the most common and serious problems facing older people. They result from the interaction of multiple and diverse risk factors and Situations, many of which can be prevented/corrected. The National Service Framework for Older people identified nine standard areas, one of which is related to falls (Standard 6) in Older People. The standard aims at preventing falls and reducing resultant fractures and providing effective treatment and rehabilitation for those who have fallen through partnership working among the key stakeholders. NICE (2004) sets out clear guideline for early identification of those at risk of falling by range of health and allied professionals followed by a Multi-factorial Risk Assessment by fall specialists.

An analysis of five year falls data (2003 -2007) show that hospital admissions due to falls have increased by 40% since 2003 and on average there has been 200 hip fractures resultant of falls every year. 30% falls are due slip, trip or stumble and 50% occur in home. There has been no significant seasonal variation. A rapid review of the falls service identified that the service was under-resourced and inequitable. Service mapping against NICE guidelines revealed a number of gaps in the service provision in particular in the community settings.

This strategy aims at reducing the number of people falling in Herefordshire by establishing an integrated falls care-pathway whereby any person who is “at risk” of falling, or has fallen, is able to access appropriate and standardised assessment, high-quality treatment and support from a wide range of service providers in order to promote a better quality of life for the residents of Herefordshire. A tiered pyramid model with three levels of service provision has been developed. It ensures that maximum number of patients will be assessed and treated in the community and only complex cases will have to go to specialist clinics. To translate this model into operational elements an integrated care pathway has been developed. It defines the role responsibilities of the various professional and sets out the explicit criteria to refer the patient to the next service level.

The strategy sets out two key targets to be achieved by 2013-14 which are:

- To reduce the hospital admission rate due to falls by 15% by 2013-14 from the base line rate of 2005 -2007 (i.e. from 1284.8 to 1092.1 per 100,000 population aged 65+ years).

- To reduce the rate of hip fractures resultant of falls by 15% by 2013-14 from the base line rate of 2005-2007 (i.e. from 415.4 to 353.1 per 100,000 population aged 65+ years).

An action plan has been developed to implement this strategy and achieve these targets. The key actions include falls road shows to raise awareness of falls, communication strategy, training for frontline health and social care

workers, periodic case finding in primary care, risk assessment of fallers in various health settings, and availability of falls clinic and falls group at the Hereford Hospital and five community hospitals. Most of the actions are in progress, but the integrated falls service will be fully operational by September 2009.

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1. Purpose

This document sets out an integrated strategy for the prevention and management of fall in older people and an action plan to implement it through multi-agency and multidisciplinary partnership working.

2. Background

Falls are among the most common and serious problems facing older people. They result from the interaction of multiple and diverse risk factors and situations many of which can be prevented/corrected. Critically, older people themselves are often not aware of their risks of falling, nor do they report the presence of risk factors to others who might be able to help.

2.1 Risk factors for falls

Several key risks factors are associated with falls and are split into intrinsic and extrinsic factors which relate to an individual's condition or environmental factors respectively.

Intrinsic risk factors

- Balance, gait or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson's disease
- Taking four or more medications, in particular centrally sedating or blood pressure lowering medications
- Visual impairment
- Impaired cognition or depression
- Postural hypotension
- Acute/chronic long term conditions

Extrinsic risk factors

- Poor lighting, particularly on stairs
- Steep stairs
- Loose carpets or rugs
- Slippery floors
- Badly fitting footwear or clothing
- Lack of safety equipment such as grab rails
- Inaccessible lights or windows
- Cold homes/inadequately heated homes
- Alcohol intake

2.2 Consequence of a fall

The consequences of a fall can be described in three categories:

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Physical Consequences: Discomfort, pain, serious injury, inability to look after oneself, long term disability

Social Consequences: Loss of independence, loss of social contacts, loss of home, move to residential care, financial costs of help/care/hospital, decreased quality of life, changes to daily routine.

Psychological Consequences: Loss of confidence, fear, distress, guilt, blame, anxiety, embarrassment, depression, fear of another fall.

2.3 National Service Framework for Older People

The National Service Framework for Older people identified nine standard areas, one of which is related to falls (Standard 6) in Older People. The standard is as follows:

Aim

To reduce the number of falls which result in serious injury
To provide effective treatment and rehabilitation for those who have fallen

To achieve this:

The NHS, working in partnership with councils, will take action to:

- Prevent falls and reduce resultant fractures or other injuries in their populations of older people
- Ensure older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

NSF Key Milestones

April 2003: Local healthcare providers should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.

April 2004: The Health Improvement Plan (HIMP), and other relevant local plans developed with local partners should include the development of an integrated falls service.

April 2005: all local health and social care systems should have established an integrated falls service

2.4 NICE Guidance

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Case/risk identification

- Older people in contact with healthcare and local authority housing professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.

- Health care and housing professionals in contact with older people should ask about their home/home conditions.

- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

Multi-factorial falls risk assessment

- 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 multi-factorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist fall's service. This assessment should be part of an individualised, multi-factorial intervention in line with the Common Assessment Framework for Adults.

- In addition an inspection of their home arranged with the local authority Private Sector Housing Team inspectors, using the Housing Act Housing Health and Safety rating system,(HHRS).

- Multi-factorial assessment may include the following:

    - identification of falls history
    - assessment of gait, balance and mobility, and muscle weakness
    - assessment of osteoporosis risk
    - assessment of the older person's perceived functional ability and fear relating to falling
    - assessment of visual impairment
    - assessment of cognitive impairment and neurological examination
    - assessment of urinary incontinence
    - Must include assessment of home hazards including (HHRS)
    - cardiovascular examination and medication review.

Multi-factorial interventions

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multi-factorial intervention.

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- In successful multi-factorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

    - strength and balance training
    - home hazard assessment and intervention including house inspections by Private Sector Housing officers.
    - vision assessment and referral
    - medication review with modification/withdrawal.

- Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.

Encouraging the participation of older people in falls prevention programmes including education and information giving

- Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

Professional education

- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

3. Epidemiology of falls and fractures

3.1 National profile

Falls are the most important type of accident and many occur in and around the home, whether it is a private home, sheltered accommodation or residential/nursing care. There may be under representation of the proportion of people who die as the result of a fall, as an elderly person can die several weeks or months after a fall. While precipitated by the fall, the cause of death may not be reported as linked to the fall. (Office of the Deputy Prime Minister (2004), Housing Health & Safety Rating System). The key features of the national falls profile highlighted in the literature are as follows:

- Around 30% of over 65's living in the community will fall per year

- Three times this number of falls remain unreported

- Over 60% of people in nursing homes fall each year

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- The rate of falls injury hospitalisation increases exponentially for over 65’s with rates being higher in women than men

- 75% of falls-related deaths occur in the home

- Of the categorised falls in older people (over 65 years), 57% were due to falls on or from stairs or steps, 18% were falling from one level to another such as out of bed and 14% were due to slipping, tripping and stumbling

- 40% of care home admissions are as a result of a fall

- Falls at ages under 75 are more often associated with extrinsic factors like uneven pavements, loose carpets, ill-fitting shoes

- Falls at ages over 75 are more often associated with intrinsic or physical factors linked with ageing

- It is estimated that syncope or loss of consciousness is responsible for 5% of falls in older people

- Falls can result in a curtailment of activity, increased isolation and dependence.

- 1 in 5 fallers require medical attention

- Approx. 5% of falls result in fracture

- Over 95% of hip fractures are falls related (spontaneous fractures being very rare.)

- Over 90% of hip fractures occur with older people with osteoporosis

3.2 Herefordshire profile

This analysis covers all Herefordshire resident/registered population admitted to all English provider hospitals. Overall the number of admissions due to falls (defined as the presence of a diagnosis code ICD10 W00-W19 in any diagnosis position) has risen by almost 40% since 2003 and averages approximately 960 per year (Figure 1). However, quarterly analysis of hospital admissions over the period indicates minimal seasonal variation in the number of admissions - an average of 235-255 per quarter (Figure 2). For the purposes of this exercise Spring is defined as March to May etc.

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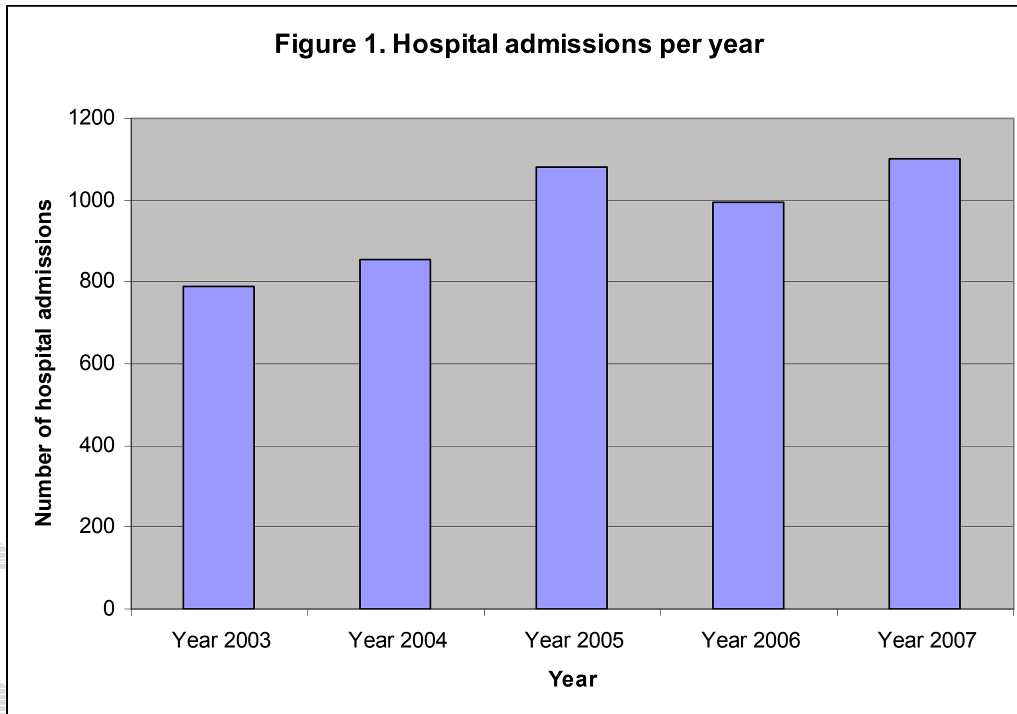

Figure 1. Hospital admissions per year

Figure 2: Seasonal Admissions Trend 2003 - 2008

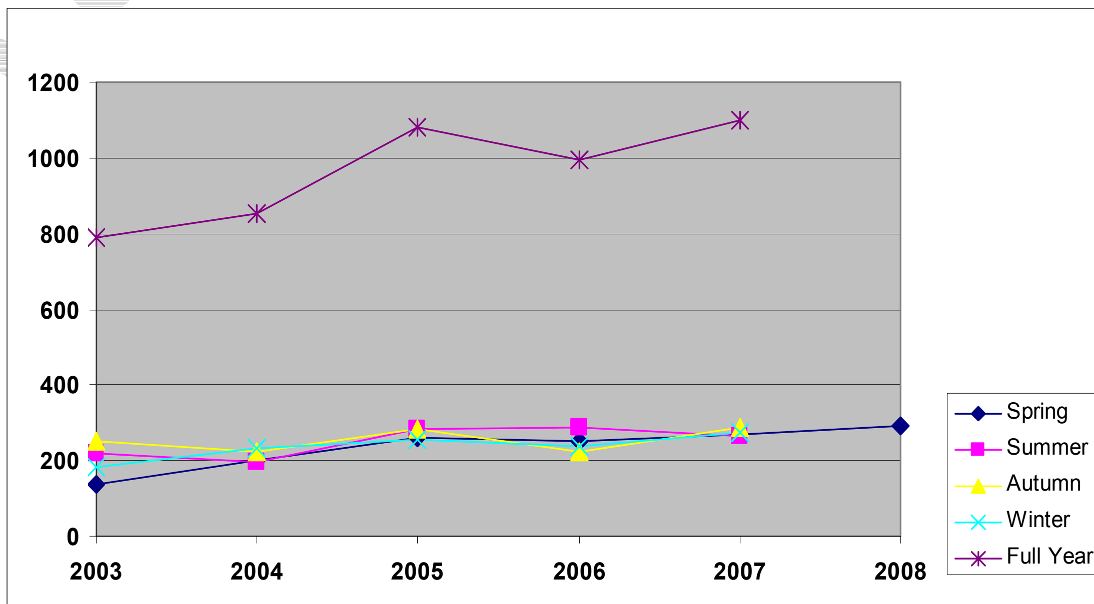

Table 1 provides a breakdown of all falls admissions by cause, as defined by the ICD10 coding classification. Almost a quarter of all falls are coded as due to unspecified causes.

Table 1: Number and Percentage of Falls by Cause (2003 to June 2008)

Cause of fall	Number	Percentage
Slip/trip/stumble	1562	29.8
Unspecified	1291	24.6
Fall on same level	578	11.0
Stairs/steps	488	9.3
Bed	203	3.9
Fall between levels	195	3.7
Playground equipment	186	3.6
Chair	157	3.0
Ice skates etc	118	2.3
Ladder	110	2.1
Collision with or pushed by other person	102	1.9
Building	73	1.4
Tree	37	0.7
Furniture	32	0.6
Ice and snow	29	0.6
Fall while being carried/supported by other person	29	0.6
Wheelchair	24	0.5
Scaffolding	14	0.3
Water diving/jumping	8	0.2
Cliff	2	0.0
ALL TYPES	**5238**	**100.0**

Table 2 provides an analysis of falls leading to hospital admission by venue – almost 50% of all such falls occur in the home. Again, over one fifth of admissions are not adequately coded in order to indicate a specific venue category.

Table 2. Number and Percentage of Falls by Venue (2003 to June 2008)

Venue	Number	Percentage
Home	2601	49.7
Unspecified	1138	21.7
Street	356	6.8
School/Public admin. building	331	6.3
Other	250	4.8
Residential Institution	243	4.6
Sports	196	3.7
Trade/service	82	1.6
Industrial	23	0.4
Farm	18	0.3
ALL VENUES	**5238**	**100.0**

Tables 3-7 below show further analysis of hospital admissions and hip fractures due falls in people aged 65 and over in period of three years from 2003 to 2005. The number of female admissions is almost three times higher

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than male admissions in age group 75 and over. Overall, the number of hospital admissions has increased by 10% from 2003 to 2005 (table 3), whereas there has been a 10% drop in hip fractures during the same period (table 6).

Table 3: Hospital admissions due to falls in ages 65 and over by age band and sex

Year	65 – 74		75 – 84		85 and over	
	Male	Female	Male	Female	Male	Female
2005	46	79	59	158	45	166
2006	43	64	62	170	40	163
2007	49	76	69	165	54	193

Table 4: Hospital admissions due to falls in ages 65 and over (EAS Rate/100,000 population)

Year	Number of admissions	EAS Rate/100,00 population
2005	553	1282.8 (1173.1 – 1392.5)
2006	542	1205.0 (1100.5 – 1309.5)
2007	606	1366.5 (1254.4 – 1478.5)
3 year baseline admission EAS rate		1284.8

Table 5: Hospital admissions due to falls in ages 65 and over by residence

Year	Hereford	Ledbury	Leominster	Kington	Bromyard	Ross	Rural	Total
2005	177	35	43	15	23	34	226	553
2006	168	36	36	12	25	30	235	542
2007	190	46	48	8	20	55	239	606
Total	535	117	127	35	68	119	700	1701

Table 6: Hip fracture due to falls in ages 65 and over

Year	Number	EAS Rate /100,000 population
2005	206	462.1 (397.2 – 526.9)
2006	185	395.6 (336.9 – 454.4)
2007	184	388.6 (330.8 – 446.4)
3 year baseline	575	415.4

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Table 7: Projected number and percentage of people aged 65 and over in Herefordshire 2005 – 14

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number	**35900**	**36300**	**37100**	**38000**	**39200**	**40400**	**41600**	**43400**	**44800**	**46300**
Percentage of the total population	**20.2**	**20.4**	**20.7**	**21.1**	**21.7**	**22.2**	**22.8**	**23.7**	**24.3**	**25.1**

4. Our vision

Our vision is to reduce the number of people falling in Herefordshire by establishing an integrated falls care-pathway whereby any person who is “at risk” of falling, or has fallen, is able access appropriate and standardised assessment, high-quality treatment and support from a wide range of service providers in order to promote a better quality of life for the residents of Herefordshire.

The service will be provided to older people irrespective of their gender, ethnicity, culture or disability.

4.1 Aims

The overarching aim of this strategy is to ensure that:

- All relevant persons from the Local Authority and Primary Care Trust who may be in contact with potential fallers have the skills and ability to identify those at risk of falling and refer them to appropriate services through the use of a single agreed assessment tool agreed by all local stakeholders.

- All persons identified as at risk of falling have timely access to a seamlessly integrated local care pathway through which access to a range of services is equitable and timely.

- Those individuals who provide a first point of contact for service users adopt standard protocols and referral criteria as agreed by all relevant agencies.

- To raise awareness and prevent falls in the community and in areas of service delivery by improving the environment in which those at risk are living.

4.2 Objectives

- To ensure safer home environments for older people living in their own home, sheltered housing and care homes

- To ensure safer hospital environments for vulnerable individuals

- To improve the mobility and activity levels of older people in the community

- To ensure systems for improving the safety of medication in relation to preventing falls

- To encourage active healthy living amongst older people

- To ensure all staff have access to relevant falls prevention information / training

- To reduce the number of specific injuries associated with falling

- To support people who have a fear of falling

- To improve screening and treatment for osteoporosis with access to bone density scanning.

- To develop health promotion activities

- To ensure high-quality treatment and rehabilitation services

4.3 Local targets

- To reduce the hospital admission rate due to falls by 15% by 2013-14 from the base line rate of 2005 -2007 (i.e. from 1284.8 to 1092.1 per 100,000 population aged 65+ years).

- To reduce the rate of hip fractures resultant of falls by 15% by 2013-14 from the base line rate of 2005-2007 (i.e. from 415.4 to 353.1 per 100,000 population aged 65+ years).

4.4 Key outcomes

- Reduced falls and associated injuries and fractures

- Co-ordinated risk assessment

- Universally adopted care pathway

- Improved partnership working

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- Better standards for effective prevention and rehabilitation services

5. Current falls service provision in Herefordshire

	NICE recommendations	Current provision
1	**Periodic case finding** from healthcare professionals and Private Sector housing officers.	Patchy within GP surgeries Reactive service from Local Authority
2	Use of '**Get up and go test'** to assess gait and balance	Patchy within GP surgeries, but regularly undertaken at falls clinics
3	**Falls Clinics:** Full evaluations for those who have required medical attention after a fall, or who have abnormalities of gait and/or balance, or who fall frequently.	Consultant lead clinics x 2 weekly Practitioner lead clinics x 2 weekly
4	**Exercise programmes:** Successful programmes are typically of more than ten weeks duration with the evidence of benefit being strongest for balance training (with Tai Chi a promising but, as yet, unproven method). Exercise needs to be maintained for sustained benefit.	Falls group run regularly in Hereford, Bromyard and Ross. Other schemes vary across Herefordshire, both in terms of capacity and the extent to which they are tailored specifically to fallers.
5	**Environmental modification:** This has greatest benefit when older patients at increased risk of falls are discharged from hospital. Evidence shows that environmental modification alone without other interventions has no proven benefit .	Carried out by OT's, housing, Local Authority Private Sector Environmental Health Officers intermediate care teams, handymen service, housing environmental officers etc but not usually as part of a broader falls prevention programme. Current capacity is limited and for the local authority, a reactive service .

6	**Medications:** Patients who have fallen should have their medications reviewed, modified or stopped as appropriate in the light of the risk of future falls. Particular attention should be paid to older persons taking four or more medications and to those taking psychotropic medications.	Reviewed regularly at falls clinics, but there is a need for a systematic approach to medication review within GP practices.
7	**Assistive devices**: Assistive devices (bed alarms, canes, walkers, hip protectors etc) are effective elements of a multi-factorial programme. Hip protectors do not reduce the risk of falling but the evidence supports their use to prevent hip fractures in very high-risk individuals.	Recommended within falls service if deemed appropriate
8 9	**Cardiovascular intervention:** Cardiac pacing should be considered for older people with cardiac-inhibitory carotid sinus hypersensitivity who have experienced unexplained falls. **Visual intervention:** Patients should be asked about their vision and, if they report problems, their vision should be formally assessed, and any remediable visual abnormalities should be treated. Those with poor vision are not only more likely to fall, they are also more	This service is available in the Hereford Hospital and they take referrals from the falls clinic. Excess Cold and Falls hazards . There may be under representation of the proportion of people who die as the result of a fall, as an elderly person can die several weeks or months after a fall. While precipated by the fall, the cause of death may not be reported as linked to the fall. (Office of the Deputy Prime Minister (2004), Housing Health & Safety Rating System) . Visual acuity is assessed in consultant led falls clinic. From primary care and other health care professionals cases are referred to opticians

	likely to suffer fractures as a consequence.	
10	**Footwear interventions**: Although there seem to be no experimental studies relating falls to footwear, some trials report better balance and reduced sway through improved footwear.	Foot care assessment is undertaken in falls clinic. Podiatry assessment is by referral to podiatry clinic.
11	**Oral and written information** should be available for those at risk of falling and their carers.	Information exists in various forms, including personal contacts, a range of leaflets, and Herefordshire NHS website.
12	Maintenance of **basic competences** among health professional dealing with those at risk of falling.	Formal training programme for professional across the board is under development.
	NICE/ RCP requirements on osteoporosis	
13	Implementation of treatment guidance following the selective case finding approach	NICE and RCP are being followed.
14	Provision of DXA (bone densitometry) scanning	DXA Scan has recently been made available and the current capacity is 1200 to 1500 per year and waiting time is 4 weeks.
15	Housing intervention	Hazards in the home assessed by local authority Housing Environmental Health Officers in private sector housing team

6. The service model

This service model for falls service will fill the gaps identified in the current service provision, planning for a gradual expansion of those components that are already in place so that the NICE recommendations are implemented.

We propose a tiered pyramid model with three levels of service provision. It ensures that maximum number of patients will be assessed and treated in the community and only complex cases will have to go to specialist clinics. The detail of service provision at three levels is as below:

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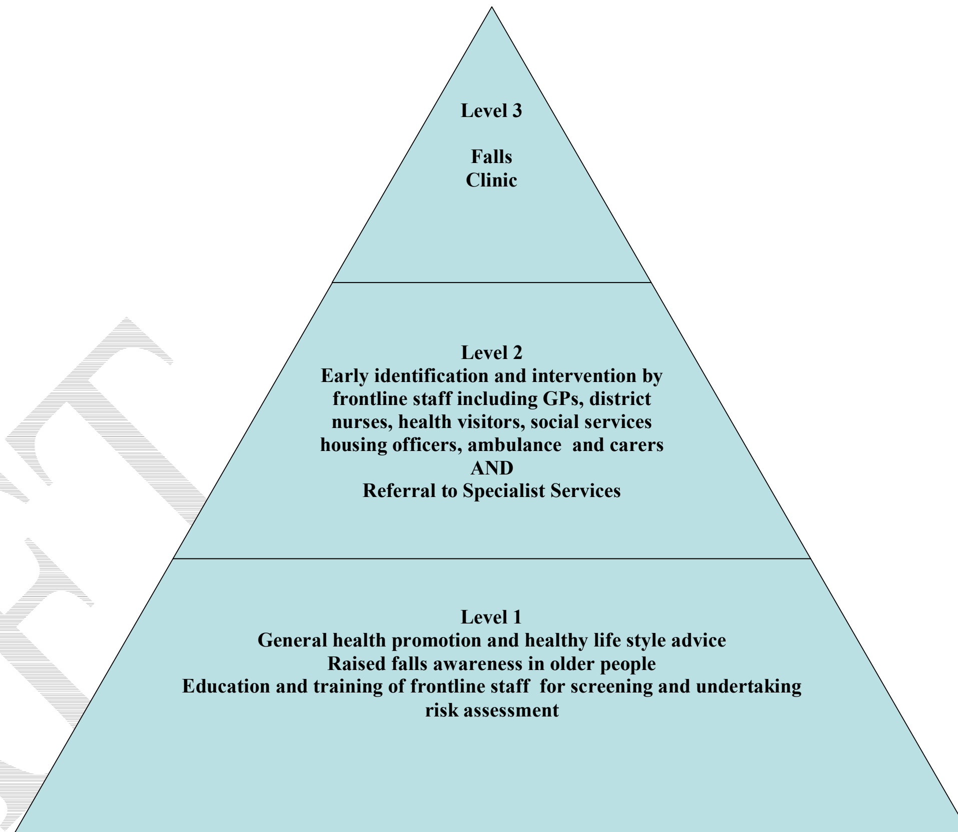

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Level 1

Level One is the foundation of this model. It includes the following:

- General health promotion and healthy life style advice from frontline healthcare professionals such as GPs, Health Visitors, District Nurses, Practice Nurses, Social Care workers, Voluntary Sector workers etc.

- Falls prevention work in the community from a wide range of professionals such as the Herefordshire Council Private Sector Housing Team undertaking HHRS home hazard inspections, leisure services providing strength and balance training in the community, pharmacists recognising medication risks etc.

Level 2

The second level involves early identification and management of falls through following activities in the community:

- Periodic case finding in primary care and offering appropriate intervention

- Risk assessment of fallers in various settings such as GP surgeries, in homes, in care homes, in acute hospitals, or in other community settings

The second level includes those who have initial contact with a faller. The diversity of these initial contacts is a challenge to the falls service since there are so many people who need to understand its processes and purpose. First contact may come, for example, with a home carer, ambulance staff, a district nurse, a GP, a sheltered housing warden, voluntary sector employee, a pharmacist Housing Officer and so on.

Where possible, this first port of call will be able to identify the cause of the fall and reverse it/prevent further falls. The pharmacist may initiate a medication review, the GP may make a referral to optometry, the district nurse may identify postural hypotension and refer the faller to the GP, the housing manager might ensure that proper lighting is introduced to a poorly lit property.

This would trigger therapeutic and practical interventions that could significantly reduce the risk of future falls. For example, assessment by a physiotherapist could lead to a targeted strength and balance training programme while occupational therapist interventions might include adaptations that allow the faller to remain independent in their own homes. The intermediate care team might also refer directly to an appropriate service or to the falls clinic if necessary.

Level 3

Level 3 is the apex of the model. It includes referral to the falls clinic for Multi-factorial Assessment of those:

- fall recurrently, or
- require medical treatment after a fall, or
- demonstrate gait and balance problems, or
- who fell after a loss of consciousness
- fall as a result of complex medical causes

and offering various forms of treatment and specialist interventions such as syncope, balance or audiology clinics.

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7. Action plan to implement the model

<u>Level 1</u> – General Health Promotion and specific measures to prevent falls and reduce the likelihood of injury

Action	Outcome	Time frame	Lead
Develop communication strategy – to raise awareness – including Herefordshire Home Check and Signposting services	Consistent message across the health and social care services and other statutory and voluntary organisation	July 2009	Vicky Howard
Falls road shows and other events to raise awareness	A structured programme of awareness raising events across the county	March 2009	Vicky Howard Jo Pewsey
Close working with voluntary sector to deliver key message	Consistent message across the health and social care services and other statutory and voluntary organisation	March 2009	Vicky Howard
Partnership working with local authority Private Sector Housing team to identify and remove/reduce home hazards	Structured framework to raise awareness of identified risks. (The Enforcement of Housing Act requires landlords to make homes safer)	On going work under the Housing Act 2004 and related legislation.	Jacqueline O'Mahony
Wider health promotion work – stop smoking, physical activity, health eating etc.	Healthy lifestyle awareness among older people	March 2009	Health Improvement Manger Older people HPT
Identify people at risk of osteoporosis	Early intervention and treatment DXA scan if deemed appropriate	On going	All GPs and clinicians in secondary care
Develop a falls register for all older people that have fallen or at risk of falling	Centralised electronic falls register for Herefordshire		Vicky Howard Health Improvement Manger – Older people HPT

			The PCT IT Team

Level 2

Action	**Outcome**	**Time frame**	**Lead**
Developing a standard training package for front-line staff including FRAT tool and “Get up and Go Test”	Early identification and intervention for potential fallers	March 2009	Vicky Howard Vicky Alner
Provide training for front-line staff who may come in contact with those who have fallen or at risk of falling	Early identification and intervention for potential fallers	March 2009	Vicky Howard Helen Crooke
Developing a standard patient care pathway	Clear referral pathway	March 2009	Vicky Howard Nicki Howard
Periodic case finding in the primary care	Early identification and intervention for potential fallers	Ongoing	Helen Crooke
Risk assessment of fallers in various settings such as GP surgeries, in homes, in care homes, in acute hospitals, or in other community settings	Risk stratification and referral for appropriate management	March 2009	Vicky Howard Vicky Alner
Referral of faller to specialised services such as podiatry, optometry and exercise programme	Early identification and intervention for potential fallers	On going	Vicky Howard
Medication review of the fallers by GPs and other clinicians	Prevention of falls and resultant fractures	On going	Vicky Howard
Assessment by the Occupational Therapists, Private Sector Housing officers, and social care to make the home environment safe	Prevention of falls and resultant fractures Prevention of further falls by ensuring hazards in the home are reduced/removed	On going	Margie Fowler Jacqueline O’Mahony George Fanning

Availability of exercise schemes through falls groups and other voluntary agencies across the county	Health improvement and wellbeing of the older people	Sept 2009	Vicky Howard Health improvement Manager

Level 3

Action	**Outcome**	Timeframe	Lead
Availability of falls clinics at all five community hospitals apart from one at HHT	Easy access to the falls clinic	March 2009	Vicky Howard Vicky Alner
Multi-factorial risk assessment	Specific care plan for the patient	March 2009	Vicky Howard Vicky Alner
Referral to specialised treatments such as for syncope, balance, audiology and cardiology clinics	Specific care plan for the patient	March 2009	Vicky Howard Vicky Alner
New post of 1 WTE OT post and 1 WTE physio post to enhance current service provision by providing specialist assessment and exercise provision	Specific care plan for the patient	September 09	Vicky Howard New OT and Physio

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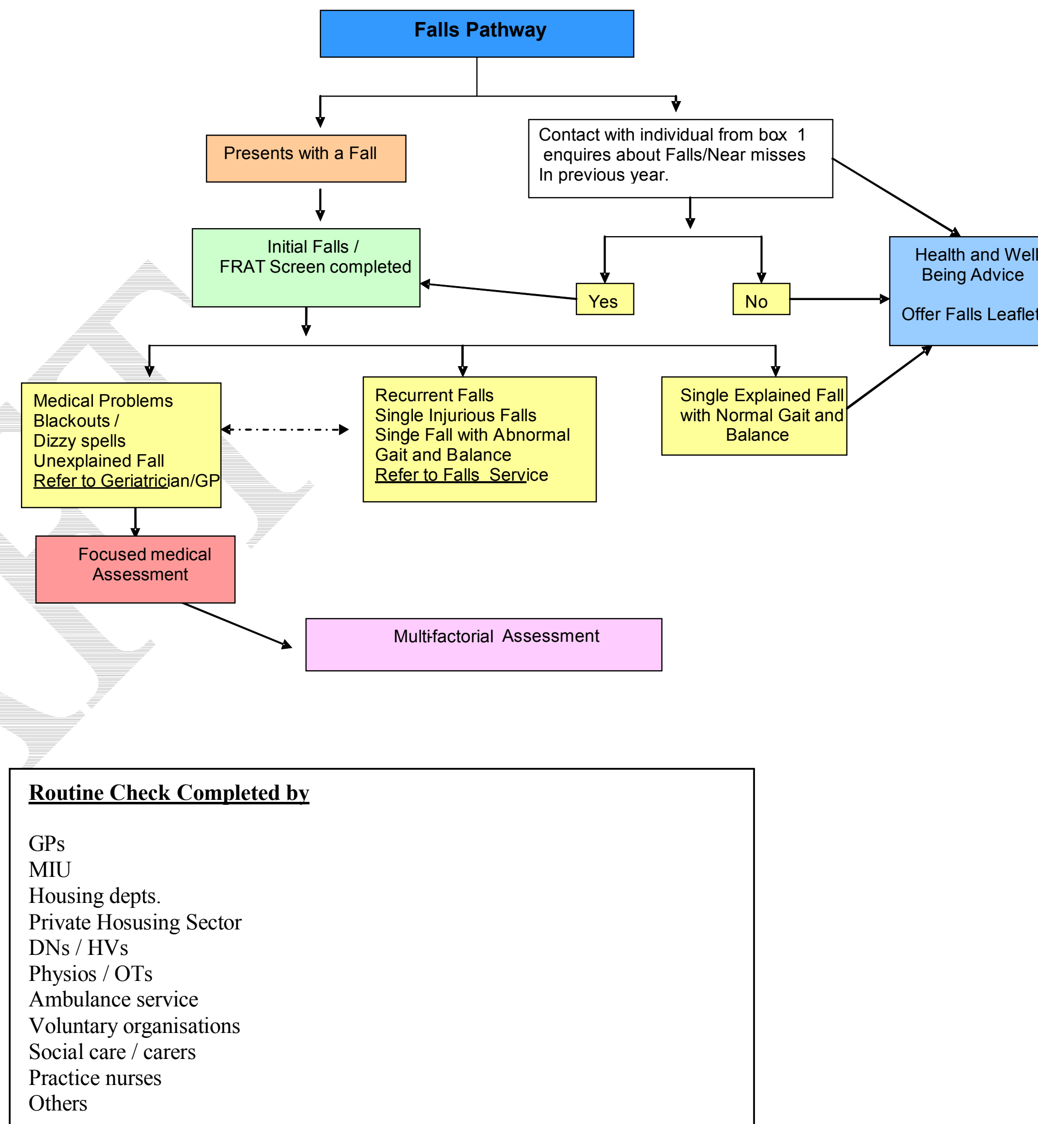
8. Integrated care pathway



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Routine Check Completed by

GPs
MIU
Housing depts.
Private Hosusing Sector
DNs / HVs
Physios / OTs
Ambulance service
Voluntary organisations
Social care / carers
Practice nurses
Others

Information Notes Relating to Care Pathway

Box1

Any opportunistic contact with an individual that confirms a previous fall or near miss will need a further appointment if FRAT assessment is not completed at first contact.

1. **Presents with a fall**

   Definition of a fall:
   " An unintentional change in position causing an individual to land at a lower level on an object, the floor or the ground, other than the consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force"

   (Tinetti et al 1997, cited in Feder et al 2000)

   - Treat any injury due to a fall before an individual enters the falls care pathway
   - Treat any acute medical condition before an individual enters the falls care pathway
   - Encourage engagement with carers
   - Consider referral to Private Sector Housing for an inspection if appropriate

2. **Routine Elderly Check**

   Older people in contact with health, social care professionals and housing departments should be asked routinely (at least once a year) whether they have fallen in the last year and about the frequency and characteristics of the fall/falls.

   NICE Clinical practice guideline for the assessment and prevention of falls in older people, 2004)

   - Enquire about falls every 6-12 months
   - Advise medicines review
   - Advise routine eyesight test
   - Advise routine podiatry
   - Advise inspection by Private Sector Housing if appropriate

3. **Health and Well Being**

   Give general advice about

- Lifestyle
- Alcohol awareness
- Healthy eating
- Home safety/housing conditions
- Exercise
- Footwear
- Hearing and sight loss
- Avoiding risk
- Information about voluntary agencies

4. Initial Falls /Osteoporosis Screen/ FRAT Screen

- Take falls history
- Check gait and balance
- Consider osteoporosis risk
- Complete FRAT screen refer as per outcome, high, moderate, low risk
- Complete "Timed Up and Go"

Medical Problem/Unexplained fall

- Reports of loss of consciousness
- Suspected blackouts, unexplained falls, dizziness

- Refer straight to GP/Geriatrician

Recurrent falls/Single Injurious fall/Single fall with abnormal gait and balance

- Recurrent falls e.g. 2 in last 6 months
- Single fall with gait/balance problems
- Single fall with injury
- Refer to Private Sector Housing re inspection if appropriate
- Refer to Falls service

Single Explained Fall

If presenting with a clear single explained fall (e.g. clear slip on ice) with stable gait and balance, give health and well being advice and review in 6-12 months

Multi- Factorial Assessment

This should be performed by a health professional with appropriate skills and experience.

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(NICE Clinical guidelines 21, 2004)

Guidance on Falls Prevention may be obtained from the following:-

- National Osteoporosis Society www.nos.org.uk
- RoSPA www.rospa.org.uk
- Leaflets and fact sheets may be accessed from Help the Aged www.helptheaged.org.uk/slipstrips

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