Up and About in Care Homes
The Management of Falls and Fractures in Care Homes for Older People Improvement Project

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• Please outline the work that is being carried out by the Up and About in Care Homes project to prevent accidents in care homes, highlighting examples of initiatives that could work well in mainstream or specialist housing for older people. It may be useful to cover the following:

• What is the value of investing in preventative measures?
• Different ways of preventing trips and falls
• Case studies or practical examples which have resulted in improvements
The National Falls Programme in Scotland (2010-present)
Up and About in Care Homes
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Care Homes

Dumfries and Galloway
- Senwick House
- Lochduhar
- Westfield House
- Fleet Valley
- Cornall Park
- Carlingwark House
- Beryl Park
- Annan Court
- Dryfremont
- Queensberry View
- Queensberry
- Thorneycroft
- Cargenholm House

North Highland
- Wyvis House
- Main's House
- Oversteps
- Sea View House
- Lochroom House
- Pulteney House
- Wade Centre
- Southside
- The Meadows
- Mull Hall
- Inverness House
- Grant House
- Fidderty House

West Dunbartonshire
- Luncraigs Centre
- Frank Townie House
- Strathleven
- Edinbarnet
- Sannindale
- Hill View
- Dalreoch House
- Mount Pleasant House
- Willox Park
- Clyde Court Care Centre
- Boquhanran House

managing falls and fractures in care homes for older people
Good practice will assessment resource

Scottish Care Support Services
NHS Scotland
Achievements (1)

- A reduction in the number of falls and the number of falls resulting in injury in care homes who have taken a proactive approach to improvement.

- Improved systems for collecting and analysing data for improvement and monitoring.
Achievements (2)

- Improved quality of practice, care and resident experience through:
  - increased **staff knowledge** and **skills** and **improvement capabilities**
  - more **integrated working** with local health and social care teams and wider community.

- Proof of the concept that **technology can be used to provide virtual specialist support** in care home settings.

- Development of a number of **resources and tools** for education, information, advice, to support daily practice in the management of falls and fractures.
Consequences
Economic cost of managing the consequences

In people aged over 65 years...

**Scottish Ambulance Service**
Falls are the largest single presentation
35,000+ attendances

**Emergency Department**
Falls are one of the leading causes of attendance

**Hospital Admissions**
Falls are responsible for 390,000+ emergency bed days

**Care Home Admissions**
Falls are implicated in up to 40% admissions

Falls cost Scotland £471 million+

45% Long Term Care
40% NHS
15% Care at Home

Craig, 2012
Consequences

Personal cost: Hip Fracture

• Approximately 1-2% of falls results in a hip fracture.

• Around **6,000** hip fractures in Scotland each year.

• The average cost of managing a hip fracture (whole system) is **£39,500**.

• 50% of people who fracture a hip will never fully recover.

• 30% will die within 6 months.

• Falls and bone health/osteoporosis are inextricably linked.
Why falls matter

For an older person a fall can be...

- trivial, profound or fatal,
- the first sign of a new or worsening health problem,
- a marker for the onset of frailty,
- a ‘tipping point’ leading to loss of confidence and independence, and increased dependence on family, and health and social services.

A fall is a symptom, not a diagnosis.

“I was never the same after the fall”
“I suddenly became an old person”
“I don’t really feel the same person”
“I was thoroughly demoralised”

NHS QIS Focus Groups, October 2008
Consequences
Personal cost

• ‘Long lies’ and complications:
  – pressure sores
  – hypothermia
  – kidney damage
  – pneumonia
  – death

• Post-fall syndrome:
  – fear of falling
  – depression
  – anxiety
  – loss of self confidence

• Avoidance of activities and social isolation / loneliness

The Fear Cycle

Todd, 2004
Targeted interventions can reduce falls

Targeted interventions, based on multifactorial risk assessment, include:

- an exercise programme incl balance, strength and gait training
- alteration of the home environment
- medication management
- management of postural hypotension (drop in blood pressure)
- foot care, management of foot problems and footwear
- treatment of visual problems
- diagnosis and management of osteoporosis
What can be done?
The Up and About Pathway

Stage One
Supporting active ageing, health improvement and self management

Stage Two
Identifying high risk of falls and/or fragility fractures

Stage Three
Responding to an individual who has just fallen and requires immediate assistance

Stage Four
Co-ordinated management including specialist assessment

http://www.scotland.gov.uk/Publications/2014/10/9431
What can be done?
A Framework for Action 2014-16

• 16 key actions for health and social care services across the four stages of the Up and About pathway.

• actions represent the minimum standard of care an older person should expect to receive.

• relevant to all partners involved in the falls and fracture prevention and management pathway.

http://www.scotland.gov.uk/Publications/2014/10/9431
What can be done?
The Framework in Summary

**Stage One is about…**

- **Providing** easy to access information about staying well, falls prevention and bone health, and

- **Sign posting** to relevant services which support falls prevention and management. *This includes resources, equipment and services which aim to support health and well being, a safe home environment and a safer community.*

**Stage Two is about…**

Through a conversation, identifying people at risk of recurrent falls who would benefit from a more personalised approach to prevention and management.

Any older person who reports a **fall**, or an **injury**, **loss of function** or **increased care needs due to a fall** has the opportunity to access further assessment and support if it is necessary.

**Stage Three is about…**

- Providing a **rapid** response to avoid a long lie on the floor, and

- An **appropriate** response, which provides both effective management of the immediate situation **and** consideration of further health and care needs.

**Stage Four is about…**

**Intervention** to:

- identify, then minimise, a person’s risk factors for falling and sustaining a fracture, and **also**

- enable recovery and independence following a fall.
Stage One of the Pathway
Supporting active ageing, health improvement and self management

Falls prevention and bone health information

Safer community environment

Keeping well
What can be done?
Online Falls and Bone Health Community

http://www.knowledge.scot.nhs.uk/fallsandbonehealth

ann.murray3@nhs.net
What can be done?
NHS Inform’s Falls Information Zone

http://www.nhsinform.co.uk
What can be done?
HDTI FALLCHECK App

https://cele.coventry.ac.uk/fallcheck/
Perth & Kinross
Up and About Pathway

Sheltered Housing Wardens may be involved in:

Stage 1: Supporting active ageing – falls prevention, health improvement, exercise/activity promotion

Stage 2: Identification of fallers and referral on for stage 4.

Stage 3: Responding to an individual who has just fallen
Learning Outcomes for P&K Falls Training Programme

• Understand the extent of the problem
• Have insight into the consequences of falling
• Have increased awareness of falls risk factors
• Identify falls risk and prevention strategies including referring on
• Involve tenants with falls prevention and have tools to deliver a Falls Education Programme for tenants.
LANARKSHIRE COMMUNITY FALLS PATHWAY

Supporting health improvement and self management to reduce the risk of falls and fragility fractures

Public Health Information

Health Promotion

Leisure

Level 1
Responding to an individual who has just fallen and requires immediate assistance and/or identifying an individual at high risk of falls and/or fragility fractures

Level 1 Screening
Completed by:- Health staff SW staff

Risk Identified by Level 1 screening Tool passed to Admin for addition to register and onward referral

No further Intervention Indicated. Passed to admin for addition to register

Falls information

Level 2 Assessment registered once complete

Admin adds to register and directs to relevant team for Level 2 assessment if indicated (DN, CPT, ICST, SW OT, CARS)

Information transferred to register

Level 2
Co-ordinated management including Specialist assessment, multifactoral Interventions with consideration of Telecare/Telehealth

Level 3
Co-ordinated management including Specialist assessment

Highly specialist Falls Assessment
Falls Clinics
Highly Specialist Falls Team

Level 3
No further intervention indicated. Passed to admin for addition to register

Level 2 completed by professionals with relevant skills no referral required via admin

Community Falls Pathway July 2014
# Level 1 Falls Screening

It is important to identify people who would benefit from further assessment after falling, or those who are at risk of falling. Complete the following Level 1 falls screening tool and send to the falls registry at the email address below.

*Please note that this is not a direct referral to the falls specialist service or falls medical clinic.*

### Basic screening questions

1. Have you fallen more than once in the last 6 months (NOT the result of simple accidental slips/trips)?
   - Yes [ ]
   - No [ ]

2. Do you have any unsteadiness on your feet, or have difficulties with your walking or balance? OR Has the screener observed any unsteadiness or difficulties with the persons walking or balance?
   - Yes [ ]
   - No [ ]

3. Did you experience a blackout or any dizziness/ light-headedness when you fell?
   - Yes [ ]
   - No [ ]

4. Have you experienced any difficulties carrying out your usual activities since you fell?
   - Yes [ ]
   - No [ ]

5. Are you worried about falling again?
   - Yes [ ]
   - No [ ]

6. Were you unable to get up from the floor after you fell?
   - Yes [ ]
   - No [ ]

If the answer is YES to any of the above questions in the shaded boxes, further assessment is required and a level 2 falls assessment needs to be completed. Please ensure the person is aware of this and is agreeable to further input.

### Additional comments regarding Level 1 Screening e.g. environmental issues/hazards/social issues/cognitive or hearing and visual impairments etc:

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### Consent to share information

The person has given informed consent (Information Sharing protocol: ISP) to share with:

- [ ] Health
- [ ] Social Work
- [ ] Leisure
- [ ] Falls Register
- [ ] Other (please specify):

Written consent obtained date: __________
Verbal consent obtained date: __________

- [ ] Declined
- [ ] Not obtained

Falls Register information leaflet supplied: [ ] Yes [ ] No

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- [ ] No further intervention required
- [ ] Requires Level 2 Assessment
- [ ] Level 2 Assessment already commenced by referrer
- [ ] Person declined further input

Supply person with falls information and send completed level 1 screenings to:

**FALLS REGISTER**
Via MIDIS or Secure Email:
falls.register@lanarkshire.scot.nhs.uk

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### Screeners information

- Name: [ ]
- Designation: [ ]
- Service/Dept/Team/Practice/Sector: [ ]
- Location/Address: [ ]
- Contact telephone number: [ ]
- Date: [ ]

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What can be done?
Do you know your Falls Lead?

What can be done?
Do you measure falls and know you have made improvement?
What can be done?
Do you identify those at risk of falls?

LANARKSHIRE CARE HOME RESIDENT FALLS AND FRACTURE RISK/INTERVENTIONS TOOL

<table>
<thead>
<tr>
<th>Risk Factors Identified</th>
<th>Identification Date and Signature</th>
<th>Action Required</th>
<th>Action Date and Signature</th>
<th>Outcome</th>
<th>Completion Date and Signature</th>
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What can be done?
Do you review the environment?

- Environmental Assessment – HOMEFAST
- Analysis of environmental Falls
- Dementia friendly environments are Falls Friendly
- Induction for new residents and their families
- Occupational Therapy assessment of a resident in their own home environment
- Opportunities to promote physical activity, enablement and reduce sedentary behaviour
- Education opportunities
- Links to other agencies
What can be done?

Do you provide information to prevent falls?

Do you know who to refer to for further support?

How do you support residents to summon help?
Pillars for success

- Falls are everyone's business everyday
- Holistic approach to the management of falls and fractures.
- Regular and ongoing dedicated support to identify, initiate, implement and sustain improvements.
- A systematic and person centred approach to falls risk assessment and management.
- Consistent data collection, reporting and analysis to identify trends and highlight areas for improvement using the data collection tool and IT dashboard.
- Committed and respected leadership empowering staff to make falls prevention and management a priority.
- Team working and shared responsibility to sustain improvements.
- Working with the integrated health and social care team and wider community.
- Sharing and learning from innovations and examples of good practice.
Improvement is not a destination..

..........It’s a continuous journey
Leaves are supposed to fall. People aren’t.
“A journey of a thousand miles begins with a single step.”
THANK YOU FOR LISTENING

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