The Prevention and Management of Falls in the Community

A FRAMEWORK FOR ACTION FOR SCOTLAND 2014/2016

Up and About

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Contents

Introduction

With health and social care services and their partners working to address the challenge of an ageing population and rising demands on public services, falls among older people are a major and growing concern. An economic evaluation published in 2013 estimated that the annual cost to health and social care services in Scotland of managing the consequences of falls was in excess of £470 million. This is set to rise over the next decade as our population ages and the proportion with multimorbidity, frailty and polypharmacy grows[1]. Less easy to quantify is the impact of falls on a person's independence and quality of life, and the repercussions for family and friends. The risk associated with not taking action to reduce falls is significant.

A fall is a symptom, not a diagnosis. It can be a marker for the onset of frailty, the first indication of a new or worsening health problem and/or can represent a tipping point in a person's life, triggering a downward decline in independence. Falls are commonly associated with frailty, but it is not only frail people who fall.

However, falls are not an inevitable consequence of old age. Many falls and fractures can be prevented by well organised services and organisations working in partnership with the person and their carers. Falls prevention and management is not the preserve of one profession, service or organisation. The consequences of a fall cut across all agencies working with older people, and with support to understand their contribution, all agencies can be part of the solution.

Effective falls prevention and management can make a significant contribution to achieving the proposed National Outcomes for Integration, specifically, supporting people to look after and improve their own health and wellbeing, live in good health for longer, live independently at home and maintain or improve the quality of their lives.

Background

Since 2010 the National Falls Programme has worked with a network of CH(C)P Falls Leads to support health and social care partnership areas to implement local integrated falls and fragility fracture pathways. The pathways enable an inclusive, systematic and evidence based approach to falls prevention and management. The model pathway is outlined in the Healthcare Improvement Scotland resource, *Up and About*[2]. (Figure 1)

The 2012 report, *Up and About or Falling Short*[3], presented the findings of a mapping exercise in Scotland which aimed to identify the extent to which recommended practices were embedded in systems of care for older people. The report suggested that although in recent years there has been progress in the implementation of local care pathways for older people who have fallen, there remains variation in service provision and quality in Scotland. An older person's likelihood of being offered evidence based care depends on where and to whom he or she presents (a) following a fall, (b) with a fracture or other fall-related injury, or (c) with increased care and support needs due to a fall. Opportunities for prevention of falls and fractures are being missed.

Stage One
Supporting active ageing, health improvement and self management

Stage Four
Co-ordinated management including specialist assessment

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

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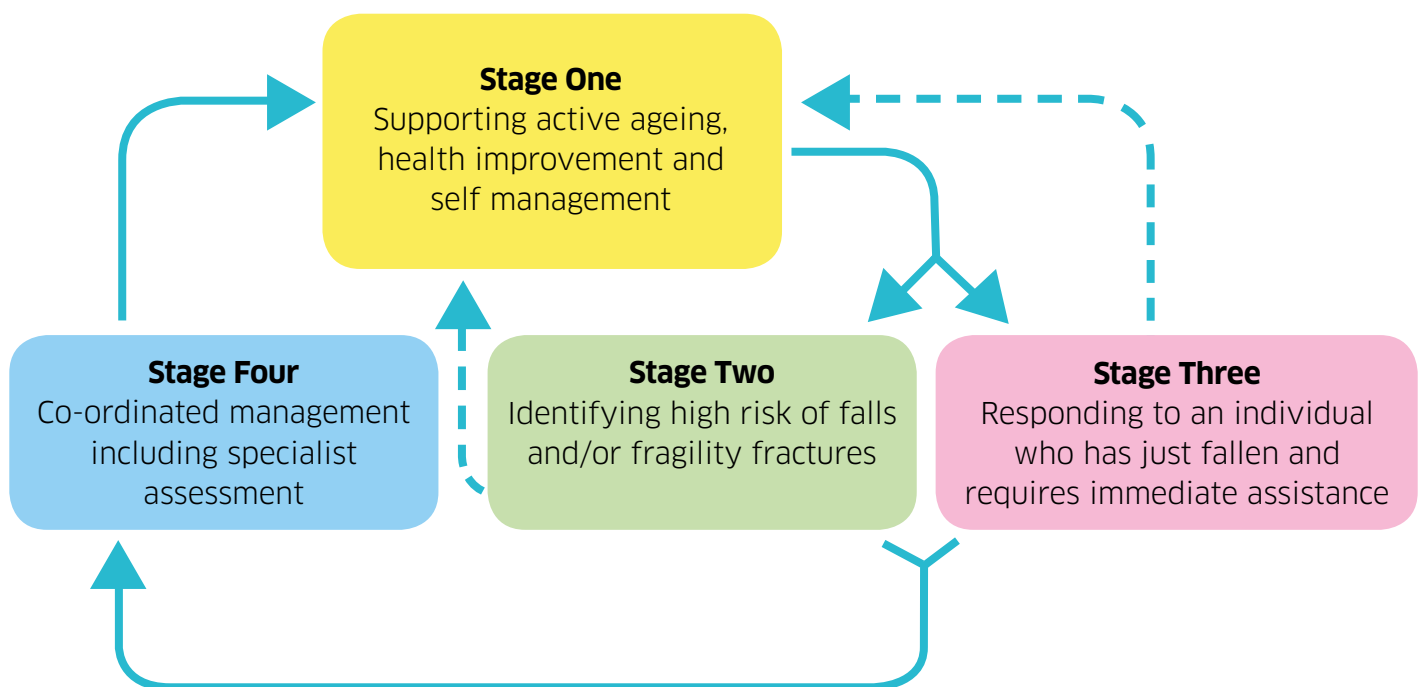Responding to an individual who has just fallen and requires immediate assistance

Figure 1 Up and About Pathway, QIS 2010

About the Framework for Action

The aim of the Framework for Action is two fold:

1. To support a more consistent approach to falls prevention and management and in doing so improve experiences and outcomes for older people, their families and carers.
2. To accelerate the pace of implementing local integrated falls and fragility fracture pathways.

The Framework builds on the model presented in the Up and About resource, and focuses on falls prevention and management and fracture prevention for older people living in the community. It is underpinned by evidence from research and draws on knowledge and experience gained by the falls prevention community in Scotland, and elsewhere, over the last four years.

The Framework identifies and describes key actions for health and social care services at each of the four stages of the pathway. These actions represent the minimum standard of care an older person should expect to receive, regardless of where and when they present to statutory services. At points throughout the pathway, statutory services will work with third and independent sector partners to deliver the actions described. Accordingly, the Framework is relevant to all partners involved in the falls and fracture prevention and management pathway. To achieve the best experience and outcomes for older people it is essential that all stakeholders work in partnership to deliver a joined up, co-ordinated and integrated pathway.

This minimum standard is a first step for 2014-16, with the intention of improving the quality of care provided in areas which have a less developed falls pathway. The Framework represents 'core business' in falls prevention and management and covers many, but not all, recommendations from clinical guidelines. Some partnership areas have already exceeded this standard in some parts of the pathway.

A significant section of the Framework focuses on screening and assessment. This is because we need to identify people who may benefit from support, and then provide individualised care. However, assessment and screening will not prevent falls in the absence of safe, effective and person-centred support and interventions. Action 4.6 focuses on evidence-based interventions.

This multiagency Framework must be taken forward with service users and their carers. Effective falls prevention and management can only be achieved through a partnership between the person, their families and carers and those delivering services. Respecting individual's needs, values, goals and choices is central to this.

Together with the Scottish Standards for Care for Hip Fracture and updated Scottish Intercollegiate Guidelines Network (SIGN) guidance on osteoporosis (both due for publication late 2014), the Framework addresses falls and fracture prevention and management at the different stages of a person's journey of care.

The Scope of the Framework for Action

Target population

The focus is on older people because of the high incidence of falls in older people and the potential seriousness of the consequences of falls in this group, specifically high morbidity and mortality and decline in quality of life. However, younger people fall too, and some actions are equally applicable. Interventions ought to be provided according to individual need rather than age. Fall and fracture risk can also be influenced by lifestyle and other factors in young and middle age, but this is not within the scope of the Framework.

Cognitive impairment, dementia and falls

People with cognitive impairment and people who have a diagnosis of dementia are at increased risk of falling. All partners in the pathway must work to ensure that people with dementia and people with cognitive impairment have equitable access to services and interventions in the same way as any other person. Service providers may need to adapt their approach to meet a person's needs. Screening and assessment processes need to include consideration of a person's capacity to make their own decisions – this is of critical importance at Stage Three of the pathway. People with dementia and people with cognitive impairment need to be involved and supported to take decisions about their care and support. Where appropriate, carers need to be involved in the assessment and planning of support, care and treatment.

Bone health, osteoporosis and fragility fractures

Falls and bone health are inextricably linked. Osteoporosis is a very common long-term condition amongst older people, particularly older women. If a person has osteoporosis, he or she is at greater risk of sustaining a 'fragility' fracture if they fall (a fragility fracture is a low trauma fracture, usually occurring from a fall from standing height or less). For this reason falls and fracture risk management must be considered in combination, and services for falls and osteoporosis (including Fracture Liaison Services and DXA services) operationally linked or dovetailed.

The Framework considers bone health in the context of falls prevention for older people. SIGN is currently updating *Clinical Guideline 71. Management of Osteoporosis*[4]. When available, it will provide specific guidance on assessment and management of fracture risk.

Secondary care

Falls prevention within secondary care is outside the scope of the Framework. However, people admitted to hospital following a fall should have the same opportunities for assessment and tailored intervention. This often requires continued management of risk following discharge from hospital, with robust referral pathways into community services aiming to support a person to restore their independence and reduce their risk of further falls. Effective communication and co-ordination is critical at times of transition.

Implementing the Framework for Action

This is a national Framework which allows scope for a local approach to pathway development involving local stakeholders, building on and integrating with existing care and support for older people. However, Scotland is a rich source of examples of successful implementation of many of these actions. Partnership areas can learn from the successes and challenges of others. Some examples are referenced in the document. More information on these and further examples can be found on the Knowledge Network's Falls and Bone Health Community: http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx.

Other local 'enablers' for pathway implementation include focused leadership, information sharing and an informed and skilled workforce.

In most CH(C)Ps/partnership areas the development of integrated pathways is being led and co-ordinated by a local Falls Lead. The Falls Leads' network has had a central role in developing the Framework for Action; contact details of Falls Leads can be found on the **Falls and Bone Health Community**.

A number of relevant awareness, education and learning resources have been developed in recent years and are currently available, details of which can be found on the **Falls and Bone Health Community**.

Implementation notes have been added to reflect some of the useful feedback received during the consultation process.

Development of the Framework for Action

The Framework for Action was developed as part of the National Falls Programme by the Programme Manager in partnership with CH(C)P Falls Leads representing all partnership areas in Scotland and other key stakeholders. It is informed by recommendations and evidence from current published guidance and research, and the tacit knowledge of health and social care professionals with subject matter knowledge and experience. Participants in the national meeting that resulted in the first draft of the Framework are listed in Appendix 1. A broad range of stakeholders have responded to a public consultation; the feedback received shaped the final document.

Policy Context

Implementation of the Framework for Action will contribute to delivering the aspirations, aims and outcomes of a number of key national policies, strategies and programmes, including:

- Healthcare Quality Strategy for NHSScotland (2011) and the 2020 Vision (2012)

- The National Delivery Plan for the Allied Health Professions in Scotland (2012)

- Co-ordinated, Integrated and Fit for Purpose: the Delivery Framework for Adult Rehabilitation in Scotland (2007)

- Reshaping Care for Older People; A Programme for Change 2010-2021

- Working together for better patient care. A strategic Framework for our people, patients and partners 2010-15

- Maximising Recovery and Promoting Independence: Intermediate Care's contribution to Reshaping Care (2012)

- Prescription for Excellence. A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation (2013)

- Gaun Yersel! The self management strategy for long-term conditions in Scotland (2008)

- Caring Together: The Carers Strategy for Scotland 2010-2011

- Scotland's National Dementia Strategy 2013-2016

- Somewhere to go and something to do. Active and Health Ageing: An Action Plan for Scotland 2014-16

- Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers (2011)

- Scottish Vision Strategy 2013-18 (RNIB Scotland)

- The Scottish Government's Unscheduled Care Programme

Effective falls prevention and management requires co-ordination and collaboration across health and social care, as well as the third and independent sectors. The integration of health and social care presents an opportunity to strengthen the planning and delivery of an integrated multiagency pathway.

Summary of Actions to achieve the minimum standard for 2014/16

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

Action 1.1
Up-to-date information on the prevention of falls and the prevention of harm from falls (including fractures) is made available to older people (and others at risk of falls), their carers and relatives.

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

Action 2.1
Health and social care services have a level 1 conversation with an older person who reports a fall *or* an injury or functional decline caused by a fall.

Action 2.2
Everyone identified at risk of further falls through a level 1 conversation is offered intervention to identify and address possible contributory factors, i.e. at least a level 2 screen.

Stage 3: Responding to an individual who has just fallen and requires immediate assistance

Action 3.1
Responding services have a standard operating procedure for responding to an older person who has fallen and has or has not sustained injuries.

Action 3.2
A responding service attends an older person who has fallen within one hour of being alerted to the fall, or as close to this timescale as possible given geographical and other constraints.

Action 3.3
Responding services have a standard operating procedure for identifying and meeting the immediate needs of an older person who has fallen.

Action 3.4
Health and social care services working with older people in their own homes (including care homes) and day care facilities have a standard operating procedure to identify and meet the immediate needs of a person who falls in their presence or is found on the floor.

Action 3.5
Responding services have a level 1 conversation with an older person presenting following a fall who is not conveyed to hospital.

Action 3.6
Services have a level 1 conversation with an older person they assist in the event of a fall who is not conveyed to hospital.

Stage 4: Co-ordinated management including specialist assessment

Action 4.1
An older person identified at risk of further falls is offered a level 2 screen.

Action 4.2
Health and social care services providing level 2 screen have a governance infrastructure to ensure suitable staff undertake the screen.

Action 4.3
Following level 2 screen the person is provided with a personalised Fall and Fracture Prevention Action Plan.

Action 4.4
Following a level 2 screen there are referral pathways into services that provide specialist assessment (level 3) and intervention.

Action 4.5
Services providing a level 2 screen can refer directly into services that provide specialist assessment (level 3) and intervention.

Action 4.6
Level 3 assessment and interventions offered are in line with current and emerging evidence.

Action 4.7
There is a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans are implemented.

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

Description (adapted from Up and About)

At this stage:

- A person is living in the community (including care homes) with support as required.
- The emphasis is on self care, supported self management, health education and promotion.
- There are opportunities for early intervention if circumstances change, therefore this stage has strong links with anticipatory care planning.
- Support for carers may be essential to achieve positive outcomes.

Rationale

Many activities and interventions at this stage contribute to active and healthy ageing generally; some are more specific to falls and fracture prevention. Physical activity warrants a special mention. Research has demonstrated that increasing physical activity not only reduces susceptibility to falls, but improves cardiovascular fitness, strength and physical function; reduces aspects of cognitive decline; and can improve aspects of mental wellbeing such as self-esteem and mood[5]. A range of local, accessible physical activity and exercise opportunities designed (or modified) for older people and others at higher risk of falls are needed.

The focus for the minimum standard 2014/16 is providing easy to access information and educational materials and sign posting to relevant services to support falls prevention and management.

Support for self management is what services provide to encourage people to take decisions and make choices that improve their health, wellbeing and health related behaviours[6]. A wide range of activities supported and/or provided by statutory, independent and third sector organisations contribute to supporting health improvement and self management to reduce the risk of falls and fragility fractures. Providing access to information is only one aspect of supporting self management, but is an important first step as part of a minimum standard.

Actions to achieve the minimum standard for 2014/16

Action 1.1

Up-to-date information on the prevention of falls and the prevention of harm from falls (including fractures) is made available to older people (and others at risk of falls), their carers and relatives.

Principles
- Information is available in local communities, clinics, care homes, day care facilities, waiting areas etc, and is also provided on a one-to-one basis as appropriate.

- The information is in a format and a language which can be understood.

- The information includes:

  - key falls prevention messages (and where to get more detailed/further information), e.g. NHS Health Scotland's *Tips to prevent trips and falls*

  - how to access resources, equipment, local services and organisations, which aim to support:

    - the maintenance of health and wellbeing, including physical activity opportunities such as exercise classes, walking groups and other community-led activities, support for medicines management and eye health checks

    - a safe home environment, including care and repair services, telecare and community alarm services and access to aids and adaptations

    - a safer community environment, including Dial-a-bus and equivalent transport services.

- To ensure consistency of message, information provided on falls and fracture prevention and management is based on materials from the following sources:

  - NHS Health Scotland

  - Age Scotland and Age UK

  - The National Osteoporosis Society

  - NHS Inform (NHS 24's online information service)

The Framework in action

NHS Ayrshire and Arran, working with the local authority partners and third sector organisations have developed the 'Positive Steps' resource to promote falls prevention awareness. The resource can be used by any service or organisation to deliver information about falls prevention and bone health to the older people they support or work with. Thirty six resource boxes are available and have been used by, amongst others, Voluntary Action South Ayrshire at community based forums and clubs and by exercise instructors at Ayrshire and Arran's Invigor8 exercise classes.

Similar resources are being used in **Highland** and the **Scottish Borders** and are reaching diverse groups of older people and their carers.

NHS Grampian has produced a credit card size information resource which directs people to their healthPOINT for further information on a range of services and organisations which can support falls prevention. The card is also handed out by Scottish Ambulance Service and at Emergency Departments.

More information and contact details for the examples provided can be found on the Falls and Bone Health Community at http://www.knowledge.scot.nhs.uk/ fallsandbonehealth/the-national-falls-programme.aspx

Further information

Encouraging positive attitudes to falls prevention

Don't mention the F word. Advice to practitioners on communicating falls prevention messages to older people. Produced by Help the Aged in 2005. Access at : http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Health-and-wellbeing/Falls%20prevention%20-%20Dont%20Mention%20the%20F-Word%202012. pdf?dtrk=true

Falls and bone health specific resources for the public

NHS Health Scotland resources:

Tips to prevent trips and falls (poster) PDF can be downloaded here: http://www.healthscotland.com/documents/23464.aspx

Up and About. Taking positive steps to avoid trips and falls (booklet) PDF can be downloaded here:
http://www.healthscotland.com/documents/23464.aspx

Copies can be ordered from NHS Health Scotland, at:
http://www.healthscotland.com/resources/publications/catalogue.aspx
or by emailing HS publications directly: nhs.healthscotland-publications@nhs.net

Age Scotland
http://www.ageuk.org.uk/scotland/health-wellbeing/keeping-healthy/preventing-falls/

Age UK
http://www.ageuk.org.uk/health-wellbeing/keeping-fit/preventing-falls/

National Osteoporosis Society
http://www.nos.org.uk/

NHS Inform Falls Prevention Zone will be available later in 2014.
http://www.nhsinform.co.uk/

Self management information

The Health and Social Care Alliance Scotland (the ALLIANCE) website is a useful source of information on self management of long-term conditions. Access at:
http://www.alliance-scotland.org.uk/

The 'My Condition, My Terms, My Life' self management campaign and website. The campaign, managed by the ALLIANCE is designed to improve public understanding of what self management means for people living with long-term conditions and enable them, as well as those who support them, to adopt a self management approach. Access at: http://www.myconditionmylife.org/

Finding community based resources

A Local Information System for Scotland (ALISS) http://www.aliss.org/

General

Silver Line Scotland (operated by Age Scotland)
http://www.ageuk.org.uk/scotland/about-us/silver_line_scotland/

Living it Up
https://portal.livingitup.org.uk/

Stage Two:
Identifying individuals at risk of falls and/or fragility fractures

Description (adapted from Up and About)

At this stage:

- A person at risk of falls and fragility fractures is identified and this triggers appropriate intervention, or referral for appropriate intervention.
- A person is identified *either* (a) when they report a fall, or present with a fall or an injury or functional decline due to a fall, *or* (b) opportunistically when someone providing care or support asks about falls.
- There is potential for third sector organisations to support this process as they may be in regular contact with a person at risk who is not know to the statutory services.
- Opportunistic case identification links with both anticipatory care and the 'shared assessment' process.
- A level 1 'conversation' aims to identify a person at risk of falling; it is not intended to determine all contributory factors or specific interventions required.

Definitions

Level 1 Conversation

A simple initial risk identification process which aims to identify people who have fallen/are at risk of falling and may benefit from further assessment and intervention. See Appendix 2 'The falls and fracture assessment continuum' for further information.

Level 2 Screen

A multifactorial falls risk screening process which aims to (a) identify risk factors for falling and for sustaining a fragility fracture, and (b) guide tailored intervention. See Appendix 2 'The falls and fracture assessment continuum' for further information.

Rationale

The focus for the minimum standard is ensuring 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. Older adults who fall once are two to three times more likely to fall again within a year[7].

Structuring and standardising the initial risk identification basic process may help improve service provider's implementation of guideline recommendations. The use of a limited number of simple questions, requiring a yes/no answer, may also simplify

documentation. Any positive answer to the questions (Have you had two or more falls in the past year? Did you have a blackout or find yourself on the floor for no apparent reason? Have you experienced any difficulties carrying out your usual activities since you fell? Do you ever lose your balance or feel unsteady on your feet?) suggests the person screened is in a high-risk group that warrants further evaluation[6].

In care homes for older people, the recommended practice is for care home staff to carry out a level 2 screen routinely on all residents[8]. In this case, a level 1 conversation is duplication and therefore not required.

For the evidence base for actions, see references seven and nine.

Actions to achieve the minimum standard for 2014/16

Action 2.1
Health and social care services have a level 1 conversation with an older person who reports a fall or an injury or functional decline caused by a fall.

Principles
- Initial risk identification i.e. a level 1 conversation aims to identify individuals who have fallen/are at risk of falling and may benefit from intervention to prevent further falls and restore/retain function following a fall.
- A level 1 conversation is a simple process, which can be facilitated by the use of a tool or an algorithm. To meet the minimum standard, a level 1 conversation identifies people who have experienced:

- two or more falls in the previous 12 months.
- loss of consciousness/blackouts/ dizziness at the time of the fall/s or an unexplained fall (found themselves on the floor for no apparent reason).
- difficulties with walking or balance.
- a change in their ability or confidence to carry out their usual day to day activities following the fall/s.
- A level 1 tool or algorithm (Figure 2) links the responses to falls questions to clear guidance for the 'screener' on what steps to take next.

Action 2.2

Everyone identified at risk of further falls through a level 1 conversation is offered intervention to identify and address possible contributory factors, i.e. at least a level 2 screen.

Principles

- As part of the conversation, the 'screener' explains to the individual the reason why the intervention is indicated, what this will involve, such as a home visit or clinic attendance, and ensures consent has been given to share information and refer for further assessment.

- There are local referral pathways to services providing level 2 screen, and agreed referral protocols.
- For people not referred for further intervention, and those who decline further intervention, up-to-date information is offered on the prevention of falls and the prevention of harm from falls (as described in Action 1.1). People declining further intervention are offered details of the appropriate service to contact should they decide at a later date they would like to receive support.

Level 1 Conversation
Identifying people who will benefit from further assessment following a fall.

Please take a moment to explain the purpose of the conversation to the individual and ensure he/she (a) has consented to referral for further assessment, and (b) understands what this will involve i.e. home visit or clinic attendance.

	Yes	No
Have you fallen in the last 12 months?		

If yes:

	Yes	No
Have you fallen more than once in the last 12 months?		
Do you have any unsteadiness on your feet, or difficulties with your walking or balance? *or*, As 'screener', have you observed any unsteadiness or difficulties?		
Did you experience a blackout when you fell or did you find yourself on the ground and didn't know why?		
Have you had any difficulties carrying out your usual activities since you fell?		

If the answer is 'yes' to any of the questions, offer referral for multifactorial risk screen.

If the answer is 'no' to all of the questions, provide information on falls prevention (written and/or web-based) and signpost to appropriate services, such as leisure, services for strength and balance classes.

Figure 2 Example of level 1 conversation pro forma

Implementation note

As a level 1 conversation is a relatively simple process, many services and organisations, including third sector organisations have the potential to contribute. Although falls prevention should be 'everybody's business', this creates potential for duplication and confusion. It is essential all stakeholders work in partnership to deliver a joined up, co-ordinated and integrated pathway.

The Framework in action

A level 1 conversation tool is being used by a range of services in **Grampian** including Emergency Departments, community alarm services, sheltered housing, day care and the Scottish Ambulance Service. Use of the tool has dramatically increased the number of people being asked about falls and improved the access to a level 2 screen – via an acknowledged pathway – and on to evidence-based services.

The tool includes six questions:

- Have you fallen recently?
- Can you remember how many falls you have had in the past year?
- Did you break any bones when you fell?
- Did you have a blackout or find yourself on the floor for no apparent reason?
- Are you able to do everything that you have done previously?
- Do you ever lose your balance or feel unsteady on your feet?

Further assessment is offered to people with two or more falls in the last year and a positive response to any of the questions.

The Integrated Community Support Team (ICST) in **East Kilbride** and the Community Alarm Social Work Service in **North Lanarkshire** are currently testing a level 1 conversation tool.

The tool asks six questions:

- Have you fallen more than once in the last six months?
- Do you have unsteadiness on your feet or have difficulties with your walking and balance (or has the screener observed any unsteadiness)?
- Did you experience a blackout or any dizziness when you fell?
- Have you experienced any difficulties carrying out your usual activities since you fell?
- Are you worried about falling again?
- Were you able to get up from the floor after you fell?

People identified as 'at risk' i.e. a positive response to any of the six questions, are asked for their consent to be placed on a falls register, which aims to improve co-ordination of care. A leaflet is provided giving them information about the register and support services available in Lanarkshire. level 2 screening is delivered by the person who initiated the level 1 conversation if it is within their scope to do so. Alternatively, the referral is forwarded to the falls register team who arrange the relevant service (including District Nursing, Occupational Therapy, the Community and Assessment and Rehabilitation Service, the ICST or social work) to carry out level 2 screening.

Forth Valley is also developing a falls register for health and social care to help with pathway co-ordination and avoid duplication of level 1 conversations and level 2 screens.

More information and contact details for the examples provided can be found on the Falls and Bone Health Community at: http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx

Further information

Clinical practice guideline: Prevention of Falls in Older Persons. Produced by the American Geriatrics Society, British Geriatrics Society in 2010. Access at: http://www.medcats.com/FALLS/frameset.htm

Clinical Guideline 161. Falls: The assessment and prevention of falls in older people. Produced by the National Institute for Health and Care Excellence in 2013. Access at: http://www.nice.org.uk/CG161

Managing Falls and Fractures in Care Homes for Older People. Produced by the Care Inspectorate and NHSScotland in 2011. Access at: http://www.scswis.com/index.php?option=com_content&view=article&id=7906:falls-and-fractures&catid=328&Itemid=725

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

Description (adapted from Up and About)
At this stage:
- A person has fallen and has requested or requires immediate assistance.
- The person may have sustained an injury and/or be unwell *or* is asymptomatic, appears uninjured but is unable to get up from the floor/ground independently.
- Appropriate onward referral and intervention at this stage may prevent further falls and unwanted consequences of falls.

Definitions
Responding services
In the context of the pathway, 'responding services' refers to all services that have designated responsibilities for responding to an older person who has fallen and requires immediate assistance. Responding services include, amongst others, the Scottish Ambulance Service, community alarm/telecare and mobile emergency care services and other dedicated falls response services (including those provided by the third sector).

Standard operating procedure
Standard operating procedures are detailed written instructions to achieve uniformity of the performance of a specific function.

Rationale
This is a critical point in the journey of care. A rapid and appropriate response, which provides both effective management of the immediate situation and consideration of further health and care needs, is key to preventing unnecessary admission to hospital, functional decline and further falls.

A consultation conducted by NHS Quality Improvement Scotland in 2009[2] identified that there is lack of clarity in some localities around which service should respond to a person who has fallen, is uninjured, but requires assistance to get up from the floor. It was reported that in a number of cases this had resulted in an older person lying on the floor, waiting for assistance for an unacceptable period of time.

The Scottish Ambulance Service will usually be the first point of contact if someone has fallen, is injured or unwell, and requires immediate assistance. It is often less clear which service should respond if a person has fallen, is uninjured but requires assistance to get up from the floor.

A 'long lie' following a fall, defined as remaining on the ground or floor for one hour or more, is associated with serious complications for an older person, including pressure ulcers, kidney damage caused by muscle breakdown, pneumonia, hypothermia, dehydration, psychological harm and even death. This is regardless of whether or not they have sustained an injury in the fall[10].

Responding services must assess the individual to ascertain (a) the presence of injury and/or illness, and (b) whether or not the individual needs to attend the Emergency Department. If there is not an immediate clinical need, attendance at the Emergency Department may not be in the interests of an older person. In some cases rapid response intermediate care services in the community can provide an appropriate alternative to Emergency Department attendance or emergency admission to hospital. This approach is described in **Making the Right Call for A Fall**[11].

Suitable decision support for responding services will ensure individuals who have fallen then receive the right care in the right place. Decision support takes a variety of forms including algorithms or triage tools, professional to professional support and a range of ehealth solutions, such as the Key Information Summary[12].

Actions to achieve the minimum standard for 2014/16

Action 3.1
Responding services have a standard operating procedure for responding to an older person who has fallen and has or has not sustained injuries.

Principles
- There is absolute clarity and agreement amongst all local responding services on arrangements for responding to:
  - injured and/or unwell individuals following a fall.
  - uninjured individuals following a fall.
- NHS 24 is informed of local arrangements for responding to an *uninjured* individual following a fall so it can respond to emergency calls appropriately and in a timely manner.

Implementation note
Local variation in 'responding services' provision often results in the Scottish Ambulance Service becoming the default responder to people who have fallen and only need help to get up again.

This is inappropriate use of a service for emergency health care. Local service provision requires to be mapped and understood before a standard operating procedure can be agreed.

Action 3.2
A responding service attends an older person who has fallen within one hour of being alerted to the fall, or as close to this timescale as possible given geographical and other constraints.

Principles
- The timing of the hour starts when the responding service receives the call and stops when the responding service is in attendance.

Action 3.3
Responding services have a standard operating procedure (SOP) for identifying and meeting the immediate needs of an older person who has fallen.

Principles
- The SOP covers:
  - assessment for the presence of injury and/or illness and management options,
  - mechanisms for assisting the person safely from the floor
  - arrangements for large or obese people
  - Suitable decision support (see above) is available to responding services to ensure individuals who have fallen receive the right care in the right place. This includes information on referral options locally, for example, intermediate care services.

Action 3.4
Health and social care services working with older people in their own homes (including care homes) and day care facilities have a standard operating procedure to identify and meet the immediate needs of a person who falls in their presence or is found on the floor.

Principles
- The SOP covers:
  - immediate actions to be taken, including how to gain access to the person's home in an emergency
  - arrangements for large or obese people.
- The service will determine appropriate actions for staff to take. This will be based on a number of factors including the nature of the service, the knowledge and skills of staff and the availability of moving and handling equipment.

Action 3.5
Responding services have a level 1 conversation with an older person presenting following a fall who is not conveyed to hospital.

Action 3.6
Services have a level 1 conversation with an older person they assist in the event of a fall who is not conveyed to hospital.

Principles

- A level 1 conversation aims to identify people who are at high risk of falling again and may benefit from intervention to prevent further falls and restore/retain function following a fall.
- A level 1 conversation is a simple process, which can be facilitated by the use of a tool or an algorithm. To meet the minimum standard, a level 1 conversation identifies people who have experienced:
  - two or more falls in the previous 12 months.
  - loss of consciousness/blackouts/ dizziness at the time of the fall/s or an unexplained fall (found themselves of the floor for no apparent reason).
  - difficulties with walking or balance.
  - a change in their ability or confidence to carry out their usual day to day activities following the fall/s.
- A level 1 tool or algorithm includes clear guidance for the 'screener' on what steps to take next, based on the outcome of the conversation.
- As part of the conversation, the 'screener' explains to the individual the reason why the intervention is indicated, what this will involve, such as a home visit or clinic attendance, and ensures consent has been given to share information and refer for further assessment.
- There are local referral pathways to services providing level 2 screen and agreed referral protocols. For responding services, referral processes require to be as simple as possible, ideally a single point of access to a range of services.
- For people referred for further intervention, written information is provided to explain what will happen next.
- For people not referred for further intervention, and those who decline further intervention, up-to-date information is offered on the prevention of falls and the prevention of harm from falls (as described in Action 1.1). People declining further intervention are offered details of the appropriate service to contact should they decide at a later date they would like to receive further intervention.

The Framework in Action

Edinburgh Health and Social Care have developed linked pathways to respond to people who have fallen at home and require assistance, but who are not injured. The Scottish Ambulance Service, NHS 24 and Edinburgh Health and Social Care have worked closely together to ensure the individual gets the right response in the most timely fashion. When an ambulance response is not required, the 'Fallen Uninjured Person' pathway ensures that individuals living without a care alarm are responded to by social care workers and will have appropriate follow-up intervention.

In addition, an 'Emergency Treat and Refer Falls Pathway' has been developed with the Scottish Ambulance Service to provide safe alternatives when a conveyance to Emergency Departments is considered unnecessary. The pathway ensures the individual has appropriate follow-up care.

Falkirk Council's Mobile Emergency Care Service has a standardised operating procedure for responding to someone who has fallen. It includes guidance on (1) action to take whether or not an obvious injury is present, (2) moving and handling, and (3) reporting and documentation.

The British Red Cross (BRC) has a Care Call Responders service in **Stewartry & Wigtown** which is delivered in partnership with NHS Dumfries and Galloway and Dumfries and Galloway Council. The commissioning partners worked with the BRC to develop an alternative telecare model which utilises trained volunteers as responders for people unable to identify local friends or family responders. The volunteers are all registered members with Disclosure Scotland and trained in: first aid, safer handling, safeguarding adults, providing emotional support and health and safety. They also have an awareness training of Care Call equipment and procedures.

More information and contact details for the examples provided can be found on the Falls and Bone Health Community at: http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx

Further information

Making the Right Call for a Fall. Produced by the Scottish Ambulance Service, the Joint Improvement Team and the National Falls Programme in 2013. Access at: http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4035271/SAS_Making_The%20Right_Call_for_a_Fall_singles.pdf

TSA Good Practice Guide. Telecare Service Providers in Scotland and the Scottish Ambulance Service – working together to improve service delivery. Produced by SCTT, JIT, Scottish Ambulance Service and the Telecare Services Association in 2013. Access at: http://www.telecare.org.uk/publications/telecare-service-providers-in-scotland-and-the-scottish-ambulance-service

Managing Falls and Fractures in Care Homes for Older People. Produced by the Care Inspectorate and NHSScotland in 2011. Access at: http://www.scswis.com/index.php?option=com_content&view=article&id=7906:falls-and-fractures&catid=328&Itemid=725

Stage Four:
Co-ordinated management including specialist assessment

Description (adapted from Up and About)
At this stage:
- A person has been identified as being at high risk of falling and/or sustaining a fracture.
- Falls risk and fracture risk management are considered in combination, with services for falls and osteoporosis operationally linked or dovetailed.
- Intervention aims to identify, then minimise, a person's risk factors for falling and sustaining a fracture as well as restoring function following a fall/s.
- Falls risk is not managed in isolation; a person's wider health status is taken into consideration when planning care. For example, the management of falls and frailty may have to be considered in combination.
- The person's GP is kept informed of outcomes of assessments and planned interventions. In many cases, the GP will be involved in, and contributing to the assessment/management process.
- Before moving from Stage Four of the pathway, back into Stage One, interventions and information have been offered which will support on-going self management.

Definitions
Level 3 assessment
A specialist assessment which aims to assess further the risk factors identified, with a view to providing tailored intervention to reduce the risk of falls and/or fractures.
See Appendix 2 'The falls and fracture assessment continuum' for further information.

Rationale
Assessment and intervention
For evidence base for standards, see references seven, nine and thirteen.

In 2011, The National Falls Programme Manager consulted with Falls Leads and other subject matter experts in Scotland to identify key components to be included in a set of 'care bundles' being developed for use in the community to prevent recurrent falls. The consultation contributors agreed that multifactorial risk factor *screening* was an appropriate and sustainable first step in the process of identifying and meeting the needs of older people identified as at high risk of falling. Blanket referral of everyone identified at high risk of falls to specialist multifactorial assessment, for example at a Consultant-led clinic, was deemed neither necessary nor feasible.

It was agreed that a multifactorial screen tool, developed in collaboration with informed stakeholders and delivered reliably, is capable of identifying the population requiring more specialist intervention.

Monitoring and quality assurance

The need for careful monitoring is identified in the American Geriatrics Society/ British Geriatrics Society Clinical Practice Guideline[7]. Nine out of ten studies in which assessment and intervention processes were carefully overseen and monitored proved to be beneficial. This contrasted with studies which provided only advice, knowledge or unmonitored referral. Recent trials of multifactorial risk assessment followed by referral without assurance of completion of the intervention have not proven effective[7].

Actions to achieve the minimum standard for 2014/16

Action 4.1
An older person identified at risk of further falls is offered a level 2 screen.

Principles
- The level 2 screen will include a falls history, general health questions and screening for risk factors related to:
  - alcohol intake related to the fall/s*
  - cardiovascular and neurological symptoms (including postural hypotension)
  - cognition*
  - environment
  - fear of falling, anxiety and depression
  - feet and footwear
  - fracture risk
  - function/activities of daily living
  - gait and balance, mobility and muscle strength
  - incontinence including urgency and frequency*
  - medications
  - nutritional status*
  - vision and hearing.
- Falls history includes:
  - Frequency of falls; how many in past week; month; 12 months.
  - Circumstances of the fall and symptoms at the time of fall.
  - Any loss of consciousness.
  - Injuries and consequences.
  - Ability to get up from floor unassisted.
  - Changes to daily function as a result of falling.
- A level 2 screening proforma is a useful tool to reliably identify risk

factors and a personalised action plan. Successfully implemented proformas:

- link risks with suggested actions,
- include red flags for urgent medical assessment (such as loss of consciousness, dizziness, unexplained falls), and
- are developed by, and agreed with, the local multidisciplinary team.

*Indicates a recommendation not included in published guidelines but agreed by the development group as good practice.

Implementation note
A number of services providing a level 2 screen:

- accept self referrals
- operate a triage process to manage referrals appropriately, both in terms of urgency and clinical need
- communicate routinely with the person's GP to share information
- have a management protocol for recurrent referrals.

Action 4.2
Health and social care services providing a level 2 screen have a governance infrastructure to ensure suitable staff undertake the screen.

Principles
- Level 2 screeners have the skills, knowledge, understanding and support to undertake their role.
- Screeners' ongoing training and supervision needs are identified and met.

Action 4.3
Following a level 2 screen the person is provided with a personalised Fall and Fracture Prevention Action Plan.

Principles
- The Fall and Fracture Prevention Action Plan is a tailored multifactorial action plan, agreed with the person (and carers, if appropriate), which addresses risk factors and issues identified in the level 2 screen. The plan reflects the person's needs, goals and choices. A person's perception and beliefs regarding their ability and motivation are taken into account when developing the plan.
- The tailored plan will include:
  - Agreed actions (including actions the person or his/her carer/s have agreed to take, and referrals to other services).
  - Reasons for recommended actions and which service is responsible for which intervention.
  - A copy of the Falls and Fracture Prevention Action Plan is provided to the person (and carers, if appropriate) in a format and language they can understand.
- Additional information provided should be relevant and available in a format and language the person can understand.

Action 4.4
Following a level 2 screen there are referral pathways into services that provide specialist assessment (level 3) and intervention.

Principles
- Services providing these interventions are identified and there are referral pathways and protocols in place.

Action 4.5
Services providing a level 2 screen can refer *directly* into services that provide specialist assessment (level 3) and intervention.
- To minimise duplication of assessment and remove unnecessary steps in the person's journey of care, there is local agreement that services providing level 2 screen have direct access to services delivering falls and fracture prevention interventions.

Action 4.6
Level 3 assessment and interventions offered are in line with current and emerging evidence.

Principles
- The Falls and Fracture Prevention Action Plan includes interventions to manage the known risk factors identified by the level 2 screen. Interventions may include:
  - Assessment of fracture risk +/- management of osteoporosis.
  - Detailed assessment of gait, balance and mobility levels and lower extremity joint function.
  - Strength and balance training, which is individualised, progressive, challenges balance and is of at least 50 hours duration (not all of which need be supervised directly).

- Assessment of the home environment for falls hazards with safety intervention.
- Assessment of activities of daily living (ADL) skills including use of adaptive equipment and mobility aids, as appropriate.
- Therapeutic interventions to improve the person's functional ability and minimise fear of falling.
- Management of risk associated with feet and footwear.
- Medication review with modification or withdrawal.
- Vitamin D supplementation.
- Medical assessment where cardiovascular and neurological problems or unexplained falls are identified.
- Management of postural hypotension.
- Management of heart rate and rhythm abnormalities.
- Assessment and management of visual impairment.
- Assessment and management of hearing impairment.*
- Education and information provision as part of a tailored multifactorial intervention.
- Continence assessment and management.*
- Nutritional assessment and advice.*
- Assessment and management of fear of falling, anxiety or depression.*

- Where cognitive impairment is recognised, refer for ongoing support as required. The action plan is adapted to reflect the individual's needs. Information provided is in a format and language the person can understand.
- Assessment of telehealthcare needs.*
- Alcohol intervention.*
- Assessments and interventions are provided by staff with suitable qualifications, knowledge and skills.
- Community-based options for on-going support and advice for self management are accessed where they are available and appropriate. Self management empowers a person to reduce their falls risk and improve their health and well being. Support may be needed to encourage a person to (a) take decisions and make the right choices to improve their health-related behaviours, and (b) adopt a positive approach to balancing risk and activity. 'Support' includes emotional support as well as information and practical support[14].
- Services providing falls prevention interventions to people with one or more long-term condition take into consideration other professionals and services involved in their care and liaise as necessary to deliver the most appropriate Falls and Fracture Prevention Action Plan and a joined-up, holistic approach.

*Indicates a recommendation not included in published guidelines but agreed by the development group as good practice.

Further information on evidence based interventions can be found below.

Action 4.7
There is a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans are implemented.

- There is a reliable process which monitors on a regular basis whether or not interventions recommended in the Falls and Fracture Prevention Action Plan are implemented as planned and agreed, and in line with the person's wishes.

Further information on evidence based interventions

Assessment of fracture risk +/- management of osteoporosis

The Scottish Intercollegiate Guidelines Network (SIGN) are currently updating Guideline Number 71 Management of Osteoporosis, with a provisional publication date of Autumn 2014.

Strength and Balance Training

Practice note
Effective exercise programmes:
* target strength, balance and gait, and challenge balance.
* are individually-tailored, taking into account the physical capabilities and health profile of the person.
* are prescribed by suitably qualified professionals or fitness instructors.
* include regular review, progression and adjustment of exercise prescription as appropriate.
* are of at least 50 hours duration (not all of which need be supervised directly).
* may be performed in groups or as individual (home) exercises.

Implementation note
There are a number of models of exercise delivery, such as group exercise or home exercise programmes. To deliver exercise classes of sufficient duration NHS services work in partnership with local authority (and other) leisure services to provide a continuum of exercise opportunities.

Further information:
Guidelines for the physiotherapy management of older people at risk of falling. Produced by AGILE, Physiotherapists working with older people in 2012. Access at: **http://agile. csp.org.uk/news/2012/08/16/guidelines-physiotherapy-management-older-people-risk-falling** (access for Chartered Society of Physiotherapy members only)

Falls Prevention Exercise – following the evidence. Produced by Age UK in 2013. Access at: **http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Falls_Prevention_Guide_2013.pdf?dtrk=true**

Exercise to prevent falls in older adults: an updated meta-analysis and best practice recommendations. Authors: Sherrington, Tiedemann, Fairhall, Close and Lord. Published in Vol. 22(3-4) 2011 NSW Public Health Bulletin Vol. 22(3-4) in 2011

Assessment of the home environment for falls hazards with safety intervention.

Assessment of activities of daily living (ADL) skills including use of adaptive equipment and mobility aids, as appropriate.

Therapeutic interventions to improve the person's functional ability and minimise fear of falling.

Further information:
Falls Management. Produced by the College of Occupational Therapists (2013) Available to buy from: http://www.cot.co.uk/publication/books-z-listing/falls-management

The College of Occupational Therapist's practice guideline, 'Occupational therapy in the prevention and management of falls in adults' will be available in January 2015.

Guidelines for the physiotherapy management of older people at risk of falling. Produced by AGILE, Physiotherapists working with older people (2012). Access at: http://agile.csp.org.uk/news/2012/08/16/guidelines-physiotherapy-management-older-people-risk-falling (access for Chartered Society of Physiotherapy members only)

Management of risk associated with feet and footwear

Further information:
Best foot forward, healthy foot supplement. Produced by Age UK for National Falls Awareness Week in 2013.
Access at: http://profound.eu.com/wp-content/uploads/2014/01/Age-UK-ID201259-Falls-Awareness-Week-2013-Supplement-Feet.pdf

The Knowldege Network's Personal Footcare portal. Access at: http://www.knowledge.scot.nhs.uk/home/portals-and-topics/personal-footcare.aspx

Medication review with modification or withdrawal

Medical assessment where cardiovascular and neurological problems or unexplained falls are identified

Management of postural hypotension

Management of heart rate and rhythm abnormalities

Supplement Vitamin D

Further information:
Clinical practice guideline: prevention of falls in older persons. Produced by the American Geriatrics Society, British Geriatrics Society in 2010.
Access at: http://www.medcats.com/FALLS/frameset.htm

Assessment and management of visual impairment

Further information:
Focus on Falls. Produced by the College of Optometrists in 2014. Access at:
http://www.college-optometrists.org/en/EyesAndTheNHS/focus-on-falls.cfm

Falls, Dementia and Sight Loss Practice Note. Produced by RNIB in 2014. Access at:
http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx

Further information on other interventions and approaches

Supporting self management

Further information:
Improving Self Management Support. Produced by the Scottish Government's Long Term Conditions Collaborative in 2009. Access at:
http://www.scotland.gov.uk/Resource/Doc/274194/0082012.pdf

Falls and dementia

Further information:
Preventing falls among people living with dementia Webinar. Hosted by Age UK in 2012. Access at: http://view6.workcast.net/register?pak=2398992394693073

Physiotherapy works. Dementia Care. Produced by the Chartered Society of Physiotherapy in 2011. Access at: http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/dementia-care

Falls, Dementia and Sight Loss Practice Note. Produced by RNIB in 2014. Access at:
http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx
Good practice in the design of living spaces for people living with dementia and sight loss.

Produced by the University of Stirling. Access at: http://dementia.stir.ac.uk/system/files/filedepot/12/good_practice_in_the_design_of_homes_and_living_spaces_for_people_living_with_dementia_and_sight_loss_final.pdf

Assessment of telehealthcare needs

Further information:
Telehealthcare and falls. Using telehealthcare effectively in the support of people at risk of falling. Produced by the University of Stirling and the Joint Improvement Team and Dementia Services Development Centre in 2011.

The Scottish Telehealth and Telcare Community. Access at: http://www.knowledge.scot.nhs.uk/telehealthcare.aspx

Falls in Care Homes

Further information:
Managing Falls and Fractures in Care Homes for Older People. Produced by the Care Inspectorate and NHSScotland in 2011. Access at: http://www.scswis.com/index.php?option=com_content&view=article&id=7906:falls-and-fractures&catid=328&Itemid=725

Living Well through Activity in Care Homes, produced by the College of Occupational Therapists, 2014. Access at: http://www.cot.co.uk/living-well-care-homes

Care… about physical activity. Produced by the Care Inspectorate and the BHF National Centre Physical Activity and Health in 2014. Access at: http://www.careinspectorate.com/index.php?option=com_content&view=article&id=8429&Itemid=100214

Good practice in the design of living spaces for people living with dementia and sight loss. Produced by the University of Stirling. Access at: http://dementia.stir.ac.uk/system/files/filedepot/12/good_practice_in_the_design_of_homes_and_living_spaces_for_people_living_with_dementia_and_sight_loss_final.pdf

The Framework in action

Level 2 screen

Level 2 screens are currently in use in the majority of partnership areas. They are delivered in a variety of ways, by a range of services. For example:
Ayrshire and Arran has trained and supervised falls screeners working within their Intermediate Care and Enablement Services.

East Renfrewshire partnership has trained and supervised falls screeners for their community alarm service clients.

Perth and Kinross has a trained falls screener who is employed by Perth and Kinross Council and is supervised by the CHP's Falls Service Manager. The screener carries out level 2 screen for community alarm clients, care at home services, local authority sheltered housing and referrals from Scottish Fire & Rescue.

Edinburgh Health and Social Care has three full-time Band 4 Falls Assistant Practitioners who complete a comprehensive level 2 multi-factorial screen. They form part of the Intermediate Care Health and Social Care team and are well placed to liaise with multiple partners across the community for on-going care and for obtaining referrals.

Greater Glasgow and Clyde has a board-wide falls service, which was the first service in Scotland to deliver level 2 screens. The level 2 screen is carried out by trained Band 4 Occupational Therapy Technical Instructors who are supervised by senior Occupational Therapists.

In **Falkirk**, level 2 screeners include Falkirk Council's Mobile Emergency Care Service.

In **Fife** nurses and AHPs from a range of services have been trained to deliver level 2 screens.

Care Homes

Care home staff in **Lanarkshire** use a level 2 screening tool which was developed by their Care Home Liaison Team. Examples of level 2 screening tools for care home staff can be found in the *Managing Falls and Fractures in Care Homes for Older People* resource pack produced by the Care Inspectorate and NHSScotland.

In **Dundee**, older people from care homes who fall, attend the Emergency Department and are not admitted are followed up to ensure that everything is done to prevent a further fall. This includes the Falls Team sharing the outcome of a telephone triage of the patient with the Care Home Liaison team who then provide ongoing support.

Personalised care plan

Fife has developed, tested and implemented a person-held Falls Prevention Plan. The Plan is created with the person who has fallen and their carer/s (where appropriate). It is produced in triplicate; the Integrated Community and Assessment and Support Service and the GP retain a copy.

Exercise

There are a number of examples of health services working with local authority, and other partners to deliver a continuum of evidence based exercise opportunities for people who have fallen or at risk of falling, including:

'Steady Steps' is a 16 week falls exercise programme taking place in nine Edinburgh Leisure Centres across the **City of Edinburgh**. Referrals are made as people are discharged from falls related community physiotherapy and occupational therapy community programmes, or are referred by their GP. This exercise class uses the Postural Stability Instructor (PSI) evidence-based approach and links with 'Community Connecting' volunteers to ensure the classes can be attended even if the individuals need support to do so.

The Integrated Care and Enablement Service working with Invigor8 in **Ayrshire and Arran**.

The Community Falls Prevention Programme working with 'Vitality' tiered exercise programme in **Glasgow and Clyde**.

There are a range of sustainable community exercise programmes in remote and rural areas of **Highland**.
- **Lorn and Oban** Healthy Options run Otago classes in remote or isolated villages in the North Argyll area. They will improve community resilience by training local volunteers to deliver classes.
- Highlife Highland have trained their staff to provide Otago in leisure facilities and in Care Homes in **North Highland**.

- Argyll Voluntary Action provide Otago classes in a variety of community settings including sheltered housing in **Cowal and Bute** and **Lomond** areas. They are also involving and training volunteers to deliver exercise in more remote areas.

Other examples

Falkirk Council's Mobile Emergency Care Service has negotiated direct referral to the Day Hospital's Falls Clinic – the person's GP is informed when the referral is made.

The Falls Service, which is part of the **Dundee** Falls Pathway operates a single point of referral (SPR) – referrals are welcome from anyone – including self-referral. The introduction of the SPR and Allied Health Professional's triage has demonstrated a reduction in waiting times for the Specialist Falls Clinic from over 10 weeks down to 3-4 weeks.

More information and contact details for the examples provided can be found on the Falls and Bone Health Community at: http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx

Measurement Plan

A suite of core improvement measures has been developed to support Partnerships, services and teams to track their progress in implementing the Framework for Action. These core measures aim to help service providers understand their local systems and the steps required to improve processes, effectiveness and outcomes of care and support.

Measurement is an essential component of quality improvement. The Framework for Action improvement measures have been designed to focus attention at key points along the Up and About pathway. Both outcome and process measures have been developed and are ready to be tested further. In the longer term, a suitable suite of measures need to be fully integrated into local service improvement work and contribute to wider performance management and reporting.

Measurement plan

Process measures (local data)

ID	Measure name	Count Operational definition	% of all people presenting or attending following a fall. Operational definition	Rate per 1000 population aged 65+ Operational definition
P1	Level 1 conversations completed	**The sample:** all people who have had a level 1 conversation completed (in the measurement period).	**The sample:** all people presenting/attending following a fall (in the measurement period).	**The sample:** all people who have had a level 1 conversation completed (in the measurement period).
		Calculating the measurement:	**Calculating the measurement:**	**Calculating the measurement:**
		Count the number of people in the sample.	**Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had a level 1 conversation completed. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	**Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.

P2	Referrals made for level 2 screen	**The sample:** all people who have been referred for level 2 screen. (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who were referred for level 2 screen. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.
			The sample: all people who have had a referral made for level 2 screen. (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.
P3	Level 2 screens completed	**The sample:** all people who have had a level 2 screen completed (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had a level 2 screen completed. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.
			The sample: all people who have had level 2 screen completed (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.

ID	Measure name			
P4	Individualised Falls and Fracture Prevention Action Plans agreed.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. The total number of patients/clients in the sample with whom an individualised Falls and Fracture Prevention Action Plan was agreed (as defined in the FfA) the sample referred for level 2 screen.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had an individualised Falls and Fracture Prevention Action Plan agreed. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	**The sample:** all people who have had an individualised Falls and Fracture Prevention Action Plan agreed (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.

Outcome measures (national, NHS board area and CH(C)P level)

ID	Measure name	Count Operational definition	% of all people presenting or attending following a fall. Operational definition	Rate per 1000 population aged 65+ Operational definition
O1	Conveyances to hospital by the Scottish Ambulance Service (SAS) following a fall (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ conveyed to hospital by the SAS following a fall (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. Data source: Data Warehouse (SAS)	**The sample:** all people aged 65-74, 75-84, 85+ presenting to the SAS following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who were conveyed to hospital by the SAS. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100. Data source: Data Warehouse (SAS)	**The sample:** all people 65-74, 75-84, 85+ conveyed to hospital by the SAS following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. Data source: Data Warehouse (SAS)

O2	Emergency admissions following a fall (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital following a fall (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. Data source: SMR01 (ISD)	**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65-74, 75-84, 85+ in the population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. Data source: SMR01 (ISD)
O3	Admissions with a hip fracture (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital with a hip fracture (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. Data source: SMR01 (ISD)	**The sample:** all people aged 65-74, 75-84, 85+with an emergency admission to hospital with a hip fracture (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65-74, 75-84, 85+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. Data source: SMR01 (ISD)

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Appendix 1: Participants in the Meeting of Falls Leads, March 2013

Representing	Name
Ayrshire & Arran	Elaine Hill Rebekah Wilson
Borders	Elaine Auld
Dumfries & Galloway	Hazel Dykes Sarah Kirk Lorraine Priestley
Fife	Moira Bell Ingrid Hale
Forth Valley	Lesley Yarrow Linda Saunders
Grampian	Shona Strachan Anne McKenzie Rosie Cooper
Greater Glasgow & Clyde	Margaret Anderson Liz Daniels Noeleen Elliot Josephine Wight Gordon Bryan Suzanne Marshall Heather Caughey Mary Angela McKenna Elaine Marsh Karen Beattie Marie Farrell
Highland	Margaret Moss Rhiannon Pitt Mary Wilson Christine McArthur Gavin Sell
Lanarkshire	Senga Cree Lianne Mcinally Sandra Lawler

Lothian	Roz Eccles Kirstin James Kirstie Stenhouse
Orkney	Carol Mainland
Shetland	Fiona Smith
Tayside	Paul Moran Lynne Houston Carolyn Wilson
Care Inspectorate	Edith Macintosh
Glasgow Caledonian University	Dawn Skelton
Scottish Ambulance Service	Christopher Conroy Elaine Kelly
Dementia Services	Sandra Shafii
National Falls Programme	Ann Murray
Scottish Government	Sarah L Mitchell

Appendix 2: The Falls and Fracture Risk Assessment Continuum

Level 1 Conversation	Level 2 Screen	Level 3 Assessment
A simple initial risk indeptification process which aims to identify people who have fallen/are at high risk of falling and may benefit from further support and/or intervention.	A multifactorial falls risk screening process which aims to (a) identity risk factors for falling and for sustaining a fragility fracture, and (b) guide tailored management.	A specialist assessment which aims to assess further the risk factors identified, with a view to providing tailored intervention to reduce the risk of falls and/or fractures.

Characteristics:

- A simple process, facilitated by the use of a tool or an algorithm.
- Clear guidance on next steps has been agreed, including referral pathways and protocols.

A level 1 conversation will identify people who have experienced:

- Two or more falls in the previous 12 months.
- Loss of consciousness/ blackouts/dizziness at the time of the fall/s.
- Difficulties with walking or balance.
- A change in ability or confidence to carry out usual daily activities following the fall/s.

Additional questions may be included which ask about:

- Previous fractures.
- Ability to get up from the floor.
- Fear of falling.

Next steps may include:

- Notifying a senior colleague/ supervisor of the outcome.
- Referral or sign posting to appropriate services providing further assessment and intervention.
- Providing further assessment or intervention, if appropriately trained/qualified.

Characteristics:

- Standard questions and/or checklist relating to falls history and specific risk factors for falls and fractures.
- Responses trigger specific interventions and/or referrals for further intervention.
- May include the use of screening tools such as the Timed Up and Go.
- Provides clear guidance on next steps to be taken if/when a risk factor is identified.
- Includes red flags for urgent medical assessment (such as loss of consciousness, dizziness, unexplained falls).

Next steps may include:

- Creating a personalised Fall and Fracture Prevention Action Plan.
- Referral on to appropriate services/agencies.
- Providing further assessment or intervention, if appropriately trained/qualified.

Characteristics:

- A more detailed assessment of a specific risk factor identified, carried out by a qualified practitioner.
- May include the use of relevant assessment tools and outcome measures.
- Determines the specific interventions required to reduce risk.

Next steps may include:

- Providing tailored intervention including support for self management.
- Referral for further intervention or investigation.

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