Adult Falls Pathway

across the community within Lincolnshire ICS

Individual presenting within Urgent and Ambulatory Care relating to a fall

Any individual that has a fall and receives response from a falls response service (listed in 'how to escalate' resource)

'Eligible' individual and/or clinically determined as 'at risk' regarding falls (see accompanying guidance)

Key
Entry point
Practitioner input stage
Pathway outcome stage

Tier 1 – Risk identification

(Click text above for more information)

Consider asking:
Have you fallen in the past 12 months?
Do you feel unsteady when standing still or walking?
Do you have concerns about falling?

No → Low falls risk → To be reviewed as appropriate via above points of entry (minimum yearly review)

Yes (Only one yes required to proceed)

Advise and Signpost

Information, Advice and Guidance resources

Consider encouraging healthy lifestyle choices, as well as promoting 'moving more' and 'physical activity' as appropriate.

Tier 2 – Risk stratification

(Click text above for more information)

Care home residents are considered 'at risk', according to guidelines, so start here.

Clinical Frailty screen ('Rockwood'; some exceptions)

And consider asking:

Have you had two or more falls in past 12 months?
Have you had any injuries when you've fallen?
When you've fallen, were you lying on the floor for ≥1hr and/or unable to get up without assistance?

Yes
(**All** yes answers and/or 'moderate' or 'severe' clinical frailty required to proceed)

No → Intermediate falls risk

High falls risk

Consider offering Strength and Balance training, Occupational Therapy (OT) & Physiotherapy (PT), as well as additional interventions including examples within boxes below, as appropriate.

Disclaimer
Many falls services' input is to manage conditions, levels of risk and/or harm associated with falls. Falls may still occur after receiving all the appropriate support.

Consider referring onwards to falls services where clinically identified, according to eligibility and local service provision (see accompanying guidance)

Tier 3 – Risk assessment

(Click text above for more information)

Multifactorial Falls Risk Assessment & Intervention Plan

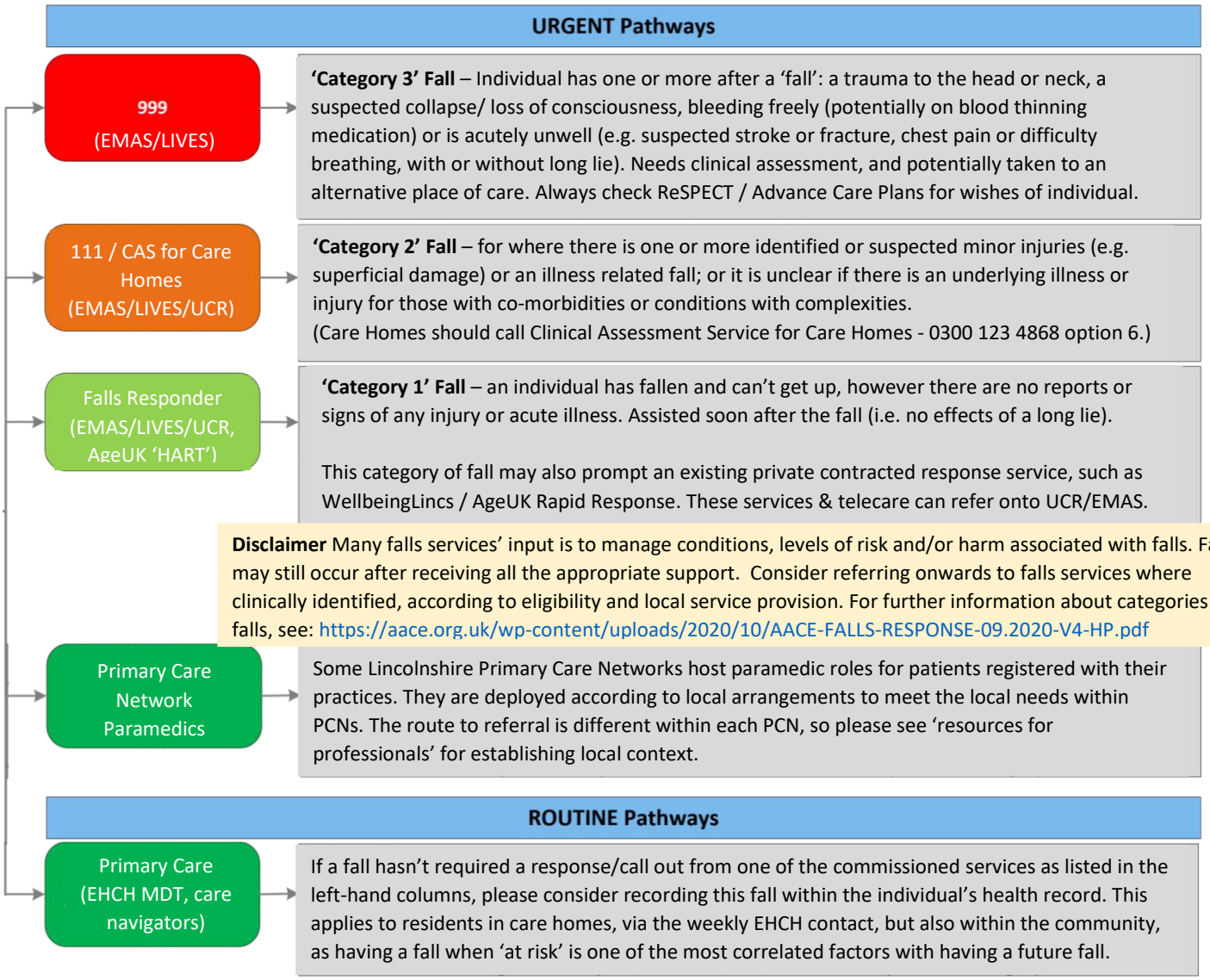
Falls risk domains are within the existing NICE guidelines (see resources for practitioners)

The service you refer on to may differ across geographical areas (see accompanying guidance)

Consider: (see accompanying guidance)

OT & PT (fear of falling, home environment, mobility etc)	Multidisciplinary team forum discussion (e.g., Neighbourhood MDT)	Strength & balance training (such as OneYou Lincs)
Fracture risk screen using 'FRAX' or 'QFracture'	Health and wellbeing coach / social prescribing referral	Advance care planning (ReSPECT, ePaCCS, CERS & PCSP plans)
Lying and standing blood pressure assessments	Vision/hearing reviews, and/or associated support services	Specialist services referral (MAMS, Continence, Heart failure etc)
Home 'Safe and Well' Check (Fire Services) and Telecare/ Lifeline	Medication Review (e.g., ACB score, problematic polypharmacy, SMR)	Specialty team referrals (HCOP, Cardiology, Neuro, ENT etc)

Lincolnshire ICS Practitioners' Guide – How to escalate support following encountering a fallen person?



This document is an amended version of the 'Guide for Care Homes – Which Service to contact' poster, created as part of the 'Care Home Information Pack', by the Lincolnshire ICB Enhanced Health for Care Homes programme.
The original document can be found here: https://eolc.co.uk/professionals/information-care-homes

Services and resources available to the public

Helping yourself

Lincolnshire falls information and resources – information from the local Lincolnshire health and social care system about falls. https://www.frailtypath.co.uk/our-services/frailty-pathway/falls-information-public

Activity Finder - Let's Move Lincolnshire – information shared by local services about their own activities. https://letsmovelincolnshire.com/find-activities/

Connect2Support - information and advice about local groups, activities and services in Lincolnshire. (0300 303 8789) https://lincolnshire.connecttosupport.org/

HAYLincolnshire (How are you Lincolnshire?) helping people in Lincolnshire to find local resources to boost their mental health and wellbeing. https://haylincolnshire.co.uk/

NHS Eatwell Guide – Advice on what to eat and drink https://www.nhs.uk/live-well/eat-well/food-guidelines-and-food-labels/the-eatwell-guide/

Suitable Footwear – Which shoes should you choose? https://www.lincolnshirecommunityhealthservices.nhs.uk/application/files/1315/0228/6620/Preventing_Falls.pdf

Disclaimer: Information accurate at time of creation. Not all services are available across the whole of Lincolnshire or bordering counties. Please check with the service to check they are available in your area and to see if there are any eligibility criteria you may need to meet.

With a little bit of support…

Below are examples of the services that can support you, many of which you can contact yourself to access:

Care Coordinator – help with navigating across the health and care system, helping people make the right connections, with the right teams at the right time. You are likely to be able to access this role through the practice you are registered with.
https://www.itsallaboutpeople.info/how/doing-things-differently/new-roles/care-coordinators

Social Prescribing Link Worker – a role that helps connect you to the 'non-medical' support that is of interest to you, within the community.
(07888 321090) https://lvet.co.uk/social-prescribing/

WellbeingLincs – a service (some at cost) that offers a helping hand through life's changes in order for individuals to live fulfilled, confident and independent lives.
(01522 782 140) www.wellbeinglincs.org/

'Community Connectors' - support individuals and groups to connect with each other. Contact details (phone) are on this webpage: https://haylincolnshire.co.uk/meet-the-team/

Lincolnshire Carers Services (includes 'Carers First') – supporting those who provide support for someone else
(01522 782 224) www.lincolnshire.gov.uk/support-carers

OneYou Lincolnshire – Provide weight loss, exercise, stop smoking and drink less programmes within Lincolnshire. (01522 705 162) https://www.oneyoulincolnshire.org.uk/

'Health & Wellbeing Coach' – empowering people to make changes to live in a way that better supports their health and wellbeing. https://www.itsallaboutpeople.info/how/doing-things-differently/new-roles/health-wellbeing-coaches

AgeUK – a charity helping individuals aged 50 years and above, their families and carers through providing services and activities (some at cost).

ageuk.org.uk/lincolnsouthlincolnshire/ (03455 564 144)

ageuk.org.uk/lindsey/ (East/West Lindsey District Councils) (01507 524242)

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(Potential) services/initiatives/onward referrals for practitioners:

Memory assessment and management service (MAMS) – https://www.frailtypath.co.uk/our-services/frailty-pathway/dementia-information

Carers Services - Carer Emergency Response Service (CERS) Plan referral - https://www.lincolnshire.gov.uk/support-carers/emergency-planning-carers

Specialist/specialty referrals (see "NHS Service Finder" below. For LCHS teams: lincolnshirecommunityhealthservices.nhs.uk/our-services/how-refer-our-services)

ReSPECT forms / ePaCCS template (see https://eolc.co.uk/)

Strength & Balance programme (health professional referral - https://oneyoulincolnshire.org.uk/pathway/strength-and-balance)
Commissioned weight loss, exercise, stop smoking and drink less programmes https://www.oneyoulincolnshire.org.uk/services

Lincs Fire Service 'Safe and Well Check' (also see 'SHERMAN' and hoarding) - https://www.lincolnshire.gov.uk/home-fire-safety/request-safe-well-check

WellbeingLincs – for support such as telecare referrals & aids at home (at cost), independence & signposting to other community services www.wellbeinglincs.org/

Social Prescribing – connecting individuals with meaningful social contact externalreferralform.socialrx.uk/SocialRxUser/BookReferral.aspx?CustomerID=5

Neighbourhood Working – a forum for services and practitioners to link together and work collaboratively across their locality for the improvement of the 'Neighbourhood' https://www.itsallaboutpeople.info/how/working-together-as-teams/neighbourhood-working

Screening tools/assessments for practitioners:

Look out! Bedside Vision assessment for falls prevention (Royal College of Physicians): https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool

Anticholinergic burden (ACB) – identify medication(s) that can increase cognitive impairment (confusion/dizziness) associated with higher risk of falls and mortality. Example resource: https://www.acbcalc.com/

Falls risk assessment tool (FRAX ®) - frax.shef.ac.uk/FRAX/tool.aspx?country=9
QFracture® - https://qfracture.org/
Evidenced tools for risk of developing major osteoporotic fracture or hip fracture.

Resources for practitioners:

Lincolnshire Primary Care Networks - https://lpcna.nhs.uk/primary-care-networks

NHS Service Finder – for both health and social care professionals https://servicefinder.nhs.uk/login

Care Portal https://careportal.lincolnshire.nhs.uk/ - for shared care plans, such as Personalised Care and Support Plan (PCSP) and also to see an individual's shared care record (e.g. historical input from across the system, who is currently involved).

'Otago', an evidenced home exercise programme, prescribed by Physiotherapists and Occupational Therapists etc. (see 'accompanying guidance' for local access).

Health and Wellbeing Coach – can support individuals with becoming more 'activated' in relation to their health and wellbeing (see 'accompanying guidance').

International World Falls Guidelines: https://academic.oup.com/ageing/article/51/9/afac205/6730755

NICE resources for Falls (https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-2-Multifactorial-risk-assessment-for-older-people-at-risk-of-falling & https://www.nice.org.uk/guidance/cg161/chapter/1-Recommendations)

National Falls Prevention Coordination Group 'Medicines and Falls' document: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Pharmacy%20guide%20docs/Medicines%20and%20falls%209%2023%20(RPSendorsed).pdf?ver=kHy696ZEbkwR7eopGgbkFw%3d%3d

Royal Osteoporosis Society resources: https://theros.org.uk/information-and-support/fact-sheets-and-booklets/

Lincolnshire ICS Resources (e.g. falls, frailty, advance care planning, ReSPECT): https://www.frailtypath.co.uk/our-services/frailty-pathway/falls-information-professionals
https://eolc.co.uk/

Lincolnshire ICS 'Medicines to consider de-prescribing' document – https://lincolnshire-pacef.nhs.uk/application/files/2916/9028/6108/FINAL_Medicines_to_Consider_Deprescribing_V1.2.pdf

Lincolnshire Joint Strategic Needs Assessment – Falls section: https://lhih.org.uk/jsna/age-well/falls/

MovingMedicine Risk Consensus - https://movingmedicine.ac.uk/riskconsensus/

Accompanying Guidance to Pathway

This pathway is designed for primary care and community settings. For falls sustained whilst an individual is a hospital inpatient, please consult relevant local pathways and guidance.

The word 'consider', as used within this pathway and accompanying guidance, indicates a conditional recommendation, which applies when the clinician examines the evidence within the wider health and social context and discusses the choices with the patient. This takes into account the patient's values and preferences as part of a shared decision making process.

NICE guidelines specify the need for 'evidence of local arrangements to ensure that older people at risk of falling are referred to healthcare professionals with skills and experience in carrying out multifactorial falls risk assessment.'

The services you may refer onto are likely to differ dependent on the available provision within the locality that the individual resides within. Please consider using 'NHS Service Finder', a national initiative created to support health and social care practitioners (see 'Resources'). For local context, it is advised that you liaise with roles operating within the respective Primary Care Network or Neighbourhood Working team where available, to determine which services are available. If you are unaware of who these practitioners may be, use Service Finder or the link for Primary Care Networks (see 'Resources') to determine who you will be best speaking with.

The falls pathway is to be used alongside existing legislation and local policies and procedures.

Eligibility

Eligibility for points of entry on the pathway are anticipated to be reviewed and adjusted periodically dependent on capacity of the system to provide the support required:

- In order to assist practitioners with determining who to refer, a minimum eligibility is detailed below: Individuals aged 65 or over whereby the individual is classified as 'moderate' or ''severe clinical frailty (from a previous assessment and/or electronic frailty index score) and have at least one condition that puts them at a higher risk of falling and/or having an injury following a fall (see NICE guidelines and/or other relevant guidelines for further information).

- Individuals aged 65 or under that are identified as 'severe' clinical frailty (from a previous assessment and/or electronic frailty index score) and have multiple long term conditions making them at higher risk of falling or having an injury following a fall (see NICE guidelines and/or other relevant guidelines for further information).

It is ultimately the involved practitioner's clinical reasoning regarding the specifics of the individual's circumstances that would determine who should be considered for the points of entry for the pathway.

Coding Interventions

For practitioners that have clinical coding available on their patient record system, the following codes are encouraged to be documented as part of your intervention:

Refer for falls assessment **– XaISu –** 717091000000109
Falls risk assessment complete **– XaJ9X –** 93001000000106

It may be possible for those services who do not have clinical coding available on their patient record system to notify the primary care practice that the individual is registered at, at the point of discharge via correspondence, so that they can consider entering this on your behalf.

Tier 1: Risk identification

Tier 1 involves determining if an individual is identifed as someone that may benefit from falls intervention. This is reflected within one of NICE guidelines' quality statements: 'Older people are asked about falls when they have routine assessments and reviews with health and social care practitioners...'

Consider checking the individual's electronic records for previous falls screening or assessment, whether through their health record directly or via Care Portal.

Consider encouraging individuals potentially 'at risk' to communicate all falls sustained, even if the fall didn't cause injury. This may assist in preventing potentially injurious falls in the future.

Tier 1 questions can be considered to be asked by anyone working in health and social care (for example, potentially a care navigator, contact centre / operations centre call handler, generic health and social practitioner) and could be included within referral forms for services providing falls related assessments/interventions. Discretion should be used, for example regarding which questions need asking if the individual has presented with fall or there's no change since a screen they've very recently had.

Information, advice and guidance should be considered. Should no further following action be required, the process will start again the next time the individual encounters one of the points of entry.

Time to complete: Approximately 5 minutes.

Tier 2: Risk Stratification

Frailty screening requires a visual component for assessment, so lends itself to an in person consultation. A previous frailty screen can only be used if it is an up-to-date assessment that is still reflective of the individual's physical functional capabilities - this decision would need to be taken under the direction of a clinician. The Lincolnshire Frailty Working group have agreed that the preferred frailty screening tool is Rockwood Clinical Frailty Scale. This is not currently verified in adults aged under 65s or individuals living with learning disabilities, and therefore Edmonton Frailty Scale should be used in these circumstances. Where a frailty screen results in a 'clinically frail' outcome (i.e. Rockwood - level 5 or above, Edmonton – score of 8 or above), the practitioner is responsible for enacting upon the outcome or, where necessary, escalating to a health care professional to enact upon the outcome.

It is up to each service to determine which practitioners are competent and appropriate to complete this tiered intervention. It is advisory for care home teams to consider liaising with their respective 'enhanced health for care homes' points of contact regarding falls.

The parameters for intermediate and high levels of risk are subject to periodical review.

Discretion should be used, for example regarding which questions need asking if the individual has presented with fall or there's no change since a screen they've very recently had.

Information, advice and guidance should be considered. Should no further following action be required, the process will start again the next time the individual encounters one of the points of entry.

Time to complete: Approximately 5-10 minutes.

Tier 3: Falls risk assessment (and intervention)

An individualised multifactorial falls risk assessment is an holistic assessment of an individual and the factors that contribute towards their potential risk regarding falls. This should be completed by a health or social care professional within a role that is able to address multiple domains in relation to falls risk.

Existing NICE guidelines outline the need for 'evidence of local arrangements to ensure that multifactorial assessment comprises multiple components to identify individual risks of falling.' There isn't a specific standardised multifactorial falls risk assessment that is recommended by the Lincolnshire Integrated Care System Falls Steering Group. There are domains in which an assessment should consider, as determined by NICE guidelines, and accessible via links within 'Resources for practitioners', as part of an individualised and person centred assessment. As this assessment is tailored to the individual, not all domains will be appropriate for further intervention. Not all potential domains and interventions are listed within the pathway.

If an assessment or intervention indicates onward referral for further and/or specialist input, please escalate this accordingly, to either the primary care GP or the involved secondary care consultant as appropriate. For individuals that have sustained a fracture following a fall, consider FRAX screen and/or DEXA scan and if not already completed and if they are aged 50+, have fallen from standing height or less and it is their first fracture.

In addition to those listed in the section 'screening tools/assessments for practitioners', the following screening tools/assessments are simple to use, evidence based and recommended to consider as clinically appropriate:

Rockwood Clinical Frailty Scale
Timed Up and Go (TUG)
Falls Efficacy Scale (FES-I)
Gait Speed
180° turn
6CIT (cognitive impairment) / DiADeM (dementia)
4AT (Delirium screen)

There is a system falls training post, working to provide support in developing the undertaking of falls work. There is an Ardens Multifactorial falls risk assessment template for use on digital patient record software for both SystmOne and EMIS.

A clinician can use their discretion if a multifactorial falls risk assessment has been completed recently and/or there is no identified change in function or need since a recent assessment.

Anticipatory falls plans are suggested to be documented as part of Advance Care Planning and as such, are encouraged to be included as part of an individual's ReSPECT form. There will be consideration for the possibility of a falls care plan to be hosted within Care Portal, which would provide an integrated tool for multidisciplinary working, as well as triaging the need for a falls assessment to clinicians across the integrated care system. These care plans would contain need-to-know information only and completed by those that have undertaken a multifactorial falls risk assessment or equivalent multifactorial holistic assessment covering falls domains initially.

Information, advice and guidance should be considered. Should no further following action be required, the process will start again the next time the individual encounters one of the points of entry.

Time to complete – as it is individualised, it will vary from person to person.