DEVELOPING AN INTEGRATED FALLS PREVENTION STRATEGY

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This article describes the development of an integrated falls prevention strategy within Sunderland Teaching PCT. It outlines the setting up of a group to implement the recommendations of the National Service Framework for Older People, and describes the development of two risk assessment tools.

Sunderland Teaching PCT covers a population of around 300,000 with 54 GP practices, a 900-bed acute hospital and two primary care centres. The falls strategy encompasses a specialist falls service within which specialist multidisciplinary and multi-agency services target older people at high risk of falling (American Geriatrics Society et al, 2001).

A working group was established to look at how falls-related objectives of the NSF for older people (DH, 2001) could be achieved. Representatives from adult services, the independent sector, intermediate care services, City Hospitals Sunderland NHS Foundation Trust, Age Concern Sunderland, North East Ambulance Service and the Sunderland Carers’ Centre were included. The aim was also to achieve strategic objectives that were identified in the Sunderland falls strategy.

Strategic objectives included the following:
- Empower patients and carers in falls prevention, service access and involvement in continued service development;
- Develop the community infrastructure to prevent falls;
- Identify older people at risk before they fall, provide appropriate assessment and treatment for those who have sustained a fall;
- Achieve a coordinated, multi-agency approach to falls prevention in all settings;
- Reduce the number of falls in older people in residential care, nursing home, community and home settings.

Although services had been developed across the boundaries between secondary and primary care, the actual care pathway was fragmented. It also became apparent that staff were unsure how to risk assess patients holistically, and where to refer them for further assessment and treatment.

There was a general lack of awareness of the services available to support those at risk of a fall or who had sustained a fall. Major training gaps were identified, especially in residential care, nursing home and community care settings.

FALLS COORDINATOR

A falls coordinator was appointed to lead implementation of the falls plan in December 2006 with the overall aim of reducing emergency admissions and re-admissions due to falls in people aged 65 and over. The plan included specific objectives such as:
- Review the use of risk assessment tools;
- Disseminate falls risk assessment tools across all relevant agencies;
- Provide training to ensure the development of appropriate skills and competencies;
- Update marketing and publicity materials;
- Develop and consolidate a falls register;
- Develop an integrated falls pathway.

RISK ASSESSMENT

There was a need to ensure patients were assessed in a consistent and coordinated manner. The same documentation should be used regardless of where they presented within the pathway to ensure a systematic assessment that would follow the patient throughout their journey.

We decided a standardised framework was needed to enable staff to assess patients in a consistent manner. In order to achieve this, two tools were developed.

The first tool is the Sunderland Trigger Tool (STT), which is used to identify patients at risk of a fall and was adapted from the ‘Cryer tool’ (PACE, 2006). Staff answer seven questions to identify whether the patient requires a more comprehensive assessment.

The STT was implemented with health professionals who come into contact with patients for brief episodes of care and do not have time to perform a comprehensive risk assessment but are able to identify those at risk and refer them appropriately. It allows a wide range of healthcare staff to become involved in falls prevention and management, including A&E staff, ambulance crews, the 24/7 team and urgent care teams. Further training has led to other groups using the STT, such as staff in the care alarm and telecare service, home help staff and practice nurses.

Information from the STT is sent to the falls coordinator. Patients with three or more positive indicators are offered a falls assessment, which involves comprehensive and holistic assessment of their general health and risk of falling. Depending on the findings this may lead to a rehabilitation exercise programme, education and/or...
BACKGROUND

- Falls among older people are a major cause of injury and death – and healthcare costs – yet many are preventable.
- Comprehensive risk assessment and multi-agency intervention is the most effective strategy to identify those at risk and reduce the incidence and impact of falls in older people (NICE, 2004).
- The National Service Framework for Older People (DH, 2001) provides an agenda for agencies to collaborate to tackle falls prevention and promote active lives for older people.
- The NSF requires healthcare providers to work with councils to prevent falls and states that people who do fall must receive effective treatment, rehabilitation and advice on prevention.

specialist referral, such as medication review, occupational therapy, social services, ‘handyman’ service, optician, the hospital’s falls clinic, community matron or specialist physiotherapy, as necessary.

The patient’s GP is also informed of the assessment and subsequent referrals. Since the launch of this work the number of patients assessed has steadily increased – in January and February 2007 there were five and three referrals respectively while June and July saw 81 and 70 respectively. This increase suggests many patients may previously have slipped through the net.

Patients with fewer than three risk factors receive advice on falls prevention and contact details for future support.

FALLS RISK ASSESSMENT TOOL

The Sunderland Falls Risk Assessment Tool is more comprehensive than the STT, including holistic risk assessments. It was developed following a review of the risk assessment tools available (PACE, 2006), and is used by staff who manage a caseload, such as community matrons, district nurses, inpatient staff and nursing home staff.

Following assessment a risk score is attributed. Previously staff had not been given appropriate information on how to manage at-risk patients, so guidance notes were developed to help them initiate appropriate management/referral (AGS, 2001).

The guidance offers specific actions for referral and stresses the need to implement some actions whether the patient is at low or high risk. It was piloted in two areas – intermediate care and mental health services – to ensure clinical credibility.

FALLS RESOURCE PACKS

To ensure a consistent approach to falls management, a resource pack was developed containing the risk assessment tools and guidance notes and a policy outlining how all the services link together. It was distributed to 54 GP practices, 67 residential and nursing homes, and all relevant agencies, such as adult services, intermediate care, community matrons, the ambulance service and the hospital.

The pack also includes a directory of all services across the city that provide a falls service or support for patients who may be at risk of or have sustained a fall. It outlines services’ referral criteria, contact details, aims and the specific care provided.

This means all staff can risk assess patients, use the guidance notes to initiate a management strategy and implement referrals using the falls directory.

FALLS REGISTER

To meet NSF requirements, we needed to set up a register to record the number of falls across the city. Information submitted by the care alarm and telecare service, ambulance service and the hospital did not provide enough detail so a database package was purchased to capture this information and establish a fully operational falls register. This will allow us to recognise trends and to identify people with repeat falls and referral pathways.

REFERENCES


TRAINING

A number of training gaps were identified and as a result monthly training sessions have been held at Sunderland Teaching PCT since March 2007, with a total of 101 staff attending. In-house training has also been run in different settings to a total of 255 staff.

Additional training purely for nursing/residential home care staff was also developed and so far 126 people have been trained, with further in-house training organised within individual homes. Those who attend training receive a resource pack outlining everything covered in the training and fully referenced for further reading. They also receive a certificate of attendance, which can be used to meet professional CPD requirements.

USER AND CARER INVOLVEMENT

All falls publicity information has been reviewed across the city and leaflets/posters have been produced to explain the purpose of the falls register, provision of home safety advice, falls prevention booklets and advice on how to get up safely following a fall. Sunderland Age Concern staff have shown the publicity materials to their clients to seek their views on the quality of the information and how effective the materials will be.

They are to be published and distributed across the city to raise awareness.