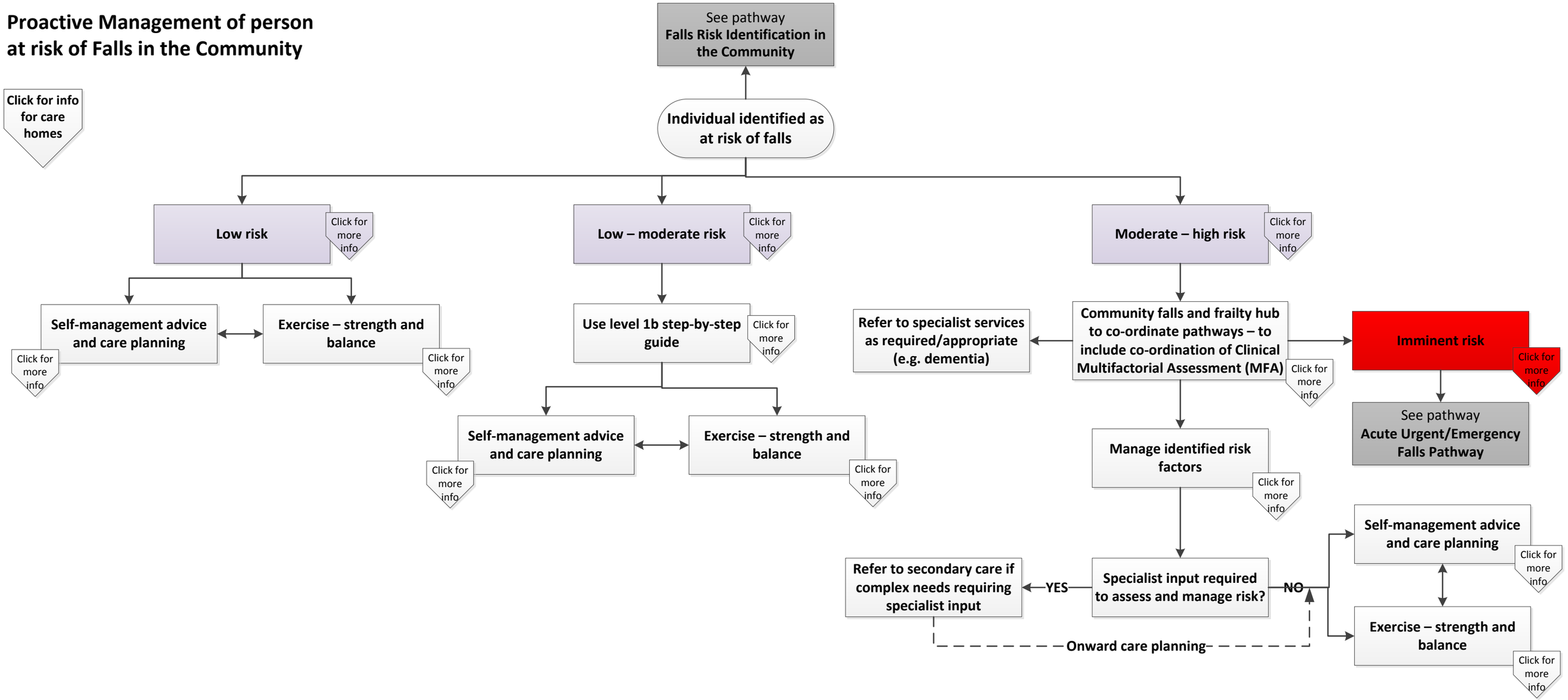
Proactive Management of person at risk of Falls in the Community



Back to pathway

Low risk

For example (all of the following dependant on how many assessments are carried out):

- Over the age of 65- no history or immediate risk of falls identified. Not yet fallen
- Scores 0 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- No concerns about person's falls risk
- No indication of frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.

Back to pathway

Self-management information

The following actions can be completed by anyone :

Signpost to:

- **Get up and Go** leaflet: http://www.csp.org.uk/publications/get-go-guide-staying-steady
- **Your step-by-step guide to staying independent and preventing falls (Hertfordshire) INSERT LINK –** this is a local guide to health and social care resources that can help people stay independent

Further assessment (as appropriate by a clinician):

- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see *Identification of Frailty* pathway)
- Carers assessment as appropriate – refer to appropriate service
- Postural hypotension assessment

Health and Social Care professionals to consider social prescribing and assessing loneliness as appropriate

Social prescribing

- Signpost to voluntary/third sector for support (e.g. HILS, Age UK)
- Promote the concept of the patient volunteering (helps loneliness wellbeing, physical activity) – signpost/ help to find opportunities to volunteer
- Advice on keeping warm
- Signpost to social opportunities (e.g. lunch clubs, local older people's groups, digital inclusion)
- Signpost to physical activities opportunities – consider exercise on referral and falls prevention
- Consider Anxiety and if required signpost to local Wellbeing Service

- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex)

  HertsHelp: https://www.hertshelp.net/hertshelp.aspx

  Contact us
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  Email: info@hertshelp.net
  Skype: HertsHelp
  Text: hertshelp to 81025
  Minicom: 0300 456 2364
  Fax: 0300 456 2365
  BSL: https://www.signbsl.com/

  Living Well Essex: https://www.livingwellessex.org/

  Contact us
  Phone: 03457 430 430 or 01245 430 430
  Textphone: 0345 758 5592
  Email: contact@essex.gov.uk
  Opening hours are 8.30am-5pm Monday to Friday.

Loneliness assessment

A number of tools are available. The UCLA Loneliness scale is described below. Staff may require training and support to ask negatively worded questions sensitively.

This scale comprises 3 questions that measure three dimensions of loneliness:
relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. How often do you feel that you lack companionship?

2. How often do you feel left out?

3. How often do you feel isolated from others?

The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response score for each question

Hardly ever = 1
Some of the time = 2
Often = 3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.
People who score 3 – 5 are usually classed as "not lonely"
People with the score 6 – 9 are usually classed as "lonely"

Back to pathway

Exercise – strength and balance

Exercise is an important part of falls risk reduction, however certain health conditions and individual fitness levels need to be considered before making a recommendation to exercise. The contraindications outlined* indicate some of the conditions to be aware of, however, if in doubt, recommend the person seeks health professional advice before commencing a new exercise programme.

Anyone recommending exercise should give the following advice:

Make sure that any exercise classes, or exercises described in guides or videos, are suitable for you and that you feel comfortable doing the exercises. If you're not sure, or if you have a heart condition or haven't been exercising regularly, speak to your healthcare professional first about what activities may best suit you.

If you experience chest pain or feel faint whilst exercising, stop exercising immediately and contact your healthcare professional. If you feel very unwell, for example chest pain does not subside on resting - call 999.

If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.

Unless clinically contraindicated recommend:

- Regular lifelong approach to exercise
- 150 minute of moderate activity per week
- Strength exercises on two or more days
- Tai Chi

Please see Hertfordshire exercise matrix for recommendations according to risk (INSERT LINK)

Recommended activities:

- Self-management and advice
- Signpost to the Get up and Go exercise advice (leaflet/online)
- General exercise classes and physical activity through public, private, voluntary and third sector exercise providers, e.g. Tai Chi

- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex) for local exercise opportunities
  HertsHelp: https://www.hertshelp.net/hertshelp.aspx

  Contact us
  Phone: 0300 123 4044
  Email: info@hertshelp.net
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  Email: contact@essex.gov.uk
  Opening hours are 8.30am-5pm Monday to Friday.
  Other information about health and care services available: *Healthwatch Essex Information Service* on 0300 500 1895.

- Signpost to NHS livewell - exercise for older adults: https://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-older-adults.aspx

***Absolute contra-indications to exercise**

There are also several absolute contra-indications to exercise which referring health professionals should be familiar with, see list below[xi]. Patients with absolute contraindications should not exercise until such conditions are stabilised or adequately treated.

Absolute contra-indications to exercise:

- A recent significant change in a resting ECG, recent myocardial infarction or other acute cardiac event[xii]
- Symptomatic severe aortic stenosis
- Acute myocarditis or pericarditis
- Resting Systolic Blood Pressure ≥ 180mmHg / DBP ≥ 100mmHg
- Uncontrolled / unstable angina
- Acute uncontrolled psychiatric illness
- New or uncontrolled arrhythmias
- Experiences significant drop in BP during exercise
- Uncontrolled resting tachycardia ≥ 100 bpm
- Febrile illness
- Experiences pain, dizziness or excessive breathlessness during exertion
- Any unstable, uncontrolled condition[xiii]

[xii] Appropriate guidance on this should be provided either by the patient's cardiologist or cardiac rehabilitation team
[xiii] Diabetes may be an exception here as exercise can help individuals' in the management of uncontrolled Diabetes

High risk

Refer patients categorised as high risk in the risk stratification to appropriate supervised physical activity

Factors

- Cardiac - Stable angina with no chest pain at rest, myocardial infarction, coronary artery bypass graft, valve replacement, pacemaker, percutaneous transluminal coronary angioplasty, heart failure
- Cardiac arrhythmias - diagnosed by cardiologist
- Hypertension - medicated but with BP of 160–180/ 95–100 mmHg
- Transient ischaemic attack - with severe disability/cognitive impairment
- Older people > 65 years at risk of falls - has fallen within the last 12 months
- Osteoporosis - BMD T score > 2.5 SD
- Claudication - with cardiac dysfunction
- Type 1 or 2 diabetes - with accompanying autonomic neuropathy, advanced retinopathy
- Severe osteoarthritis/rheumatoid arthritis - with associated immobility
- Moderate to severe asthma - where ventilatory limitation restrains sub-maximal exercise
- COPD/emphysema - with true ventilatory limitation
- Severe psychiatric illness - cognitive impairment, dementia, schizophrenia
- AIDS - with accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection

Please follow **hyperlink** for PDF version with active links

Falls framework for postural stability and exercise in Hertfordshire

	No immediate risk / Low risk of falls	Low – moderate risk of falls	Moderate- high risk of falls
Descriptor	• Over the age of 65- no history or immediate risk of falls identified. Not yet fallen • Scores 0 on the Falls Risk Assessment Tool (FRAT)	• Mild deficit in strength and balance. No more than 1 fall in last 12 months. Reduced confidence Judged at low risk of recurrent falls • Score 1-2 on the Falls Risk Assessment Tool (FRAT)	• Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk Mild deficit in strength and balance plus cognitive/ motivational issue • Score 3 and above on the Falls Risk Assessment Tool (FRAT)
Assessment Options	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) (optional) • Multifactorial assessment (optional)	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) • Multifactorial assessment
Who could refer	All	All	GP/ Health and Social Care Professionals/ Other community providers
Activity	• Self-management & advice • Signpost to Herts Help for local exercise opportunities • Signpost to the Get up and go exercise advice (leaflet/online) • General exercise classes and physical activity through public, private, voluntary & third sector exercise providers, e.g. Tai Chi	Exercise continuum based on identified need: • Individualised self-management • Tai Chi, positive movement and older peoples exercise class • Long-Term Conditions specific classes • OTAGO*/ Postural stability classes	Exercise continuum based on identified need: • Individualised Self-management programme • Individualised strength and mobility exercises if unable to begin balance exercises / PSI/OTAGO • Community OTAGO/ Postural Stability class • Home-based OTAGO programme • Home-based Physio/OT
Time	• Regular lifelong approach to exercise • 150 minute of moderate activity per week • Strength exercises on two or more days	• Lifelong approach to exercise • Minimum of 2 times per week • Balance and coordination exercise at least 2 days a week	• 50 hours (3 hours per week - 1-hour class + 2 hours independently) Arrangements for maintaining and review post course completion • Recommendation can depend on the individual needs, capacity & ability • Lifelong approach to exercise

* An evidence based exercise programme to improve balance, muscle strength, general fitness and well-being

Back to pathway

Low – moderate risk

For example (all of the following dependant on how many assessments are carried out):

- Mild deficit in strength and balance
- No more than 1 fall in last 12 months - judged at low risk of recurrent falls
- Reduced confidence
- Score 1-2 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- Mild concerns about person's falls risk
- No indication of frailty, or indication of mild frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.

Back to pathway

Level 1b - Step-by-step guide to staying independent and preventing future falls in Hertfordshire (LINK)

In people who have some falls risks identified (e.g. FRAT 1-2), the step-by-step guide can be used to look more specifically at risk factors and advise on next steps.

The step-by-step guide can be used by all (including self-assessment).

If the person is unable to complete it themselves, they can be guided through it with help from anyone.

If multiple risks of falls are identified using 1b step-by-step guide requiring further input from a health care professional, please refer to the Falls and Frailty hub

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral.

In all people:

Record:
Document the outcome of the assessment. Keep a list of people identified as being at risk of falls.
If the patient has a care plan folder, please document in here the assessment including date and outcome.

Follow up
Have a plan in place to ensure the individual has their falls risk assessed regularly

Please follow **hyperlink** for PDF version with active links

Your step-by-step guide to staying independent and preventing falls

No.	Question	✓	If 'yes'-
Red flag	Have you had any **unexplained falls**? For example at the time of your fall did you: •Feel dizzy? •Lose consciousness or blackout? •Have palpitations? •Or, just found yourself on the floor and didn't know why?		Talk to your GP about dizziness/light-headedness, blackouts or palpitations. Call/make an appointment as soon as possible
1	Have you fallen more than twice in the last 6 months?		Talk to your GP, practice nurse or other Health & Social Care Professional about fall and how it has affected you, as a healthier lifestyle reduces your risk of falls.
2	Are you taking more than 4 regular medicines? This includes over the counter ones.		Have your medicine reviewed every year by GP. Ask your pharmacist about a medicine use review. Some medicines affect your balance.
3	Do you have an illness like Parkinson's, MS or a Stroke that has left you with poor movement?		Talk to your GP or healthcare team about changes in your condition such as a worsening of your balance, more difficulty moving or loss of strength. Physiotherapy or exercise may help you to deal with the way you move around.
4	Are you unsteady on your feet or have concerns about your balance?		Talk to your GP, practice nurse or other Health & Social Care Professional about your balance. Physiotherapy, exercise or a medication review may help you improve this.
5	Have you broken any bones after the age of 50 & not had a recent bone health check?		Talk to your GP or practice nurse about a further assessment of bone health. You can learn more about bone health here.
6	Do you feel dizzy or light-headed at times? For example when you move from lying to sitting or when you stand up.		Talk to your GP, practice nurse or other Health & Social Care Professional as you may have a treatable medical condition.
7	Are you unable to get up from a dining room style chair, without using your arms?		Consider exercise to improve your strength and balance or contact Herts Help on 0300 123 4044 for advice on local exercise classes, including Postural Stability classes.
8	**Do you drink more than the recommended limit of alcohol (14 units a week over 3 days or more)? Do you use alcohol to help you sleep or control pain?**		**Alcohol can increase your risk of falls. Reducing your alcohol intake can help, you can find more information at your GP surgery or online. If you would like more support, speak to one of the Herts Help team on 0300 123 4044 who will be able to put in you touch with a local service that can support**
9	Do you get about less than you would like because you are worried about slipping, tripping or falling?		Talk to your Health & Social Care Professional, practice nurse or GP Practice about your concerns. You can learn more about how to manage this in the Getup and Go leaflet; you can find this online or ask a Health & Social Care Professional for a paper copy.
10	Do you find it hard to be regularly active? The recommendation is 30 minutes, 5 times a week e.g. gardening, vigorous housework, cycling and daily walks.		Exercise improves your health and wellbeing. Contact Herts Help on 0300 123 4044 for advice on local exercise classes, including Postural Stability classes. Experts also recommend twice weekly muscle strengthening exercises for the over 65s
11	Has your eyesight got worse in the last year? Have you had your eyes tested in the last 24 months?		Have your eyes tested by your optician in a shop or at home? Multifocal glasses can contribute to difficulty walking on stairs. Clean your glasses daily.
12	Do you have any problems with your bladder or bowel? For example, do you need to get up in the night to go to the loo?		Discuss this with your GP as they will be able to refer you to The Adult Bladder and Bowel Care Service. They may be able to help
13	Does your home have trip hazards, for example; loose mats or cluttered walkways or poorly lit stairs?		Help is available to check how safe your home is, contact Herts Help who can set up a home assessment by the Fire Brigade or an assessment for equipment (e.g. Grab rails) or advice on clutter
14	Do you drink less than six to eight cups of fluid each day, (fluid includes any non-alcoholic drink e.g. water, fruit juice, tea, coffee and milky drinks)?*		Dehydration has been shown to increase the risk of falls, so it is important to stay hydrated. A guide to keeping hydrated (including a urine colour chart) is available here.
15	Do you wear loose or poorly fitting shoes or slippers?		Buy the correct size shoes and slippers with a good fit around the heel.
16	Do you have difficulty taking care of your feet?		You may need to see a chiropodist/podiatrist for more specialized help with foot problems.
17	Do you know what to do if you had a fall?		You can learn more about how to manage a fall if you have one by reading the GetUp and Go leaflet, you can find this online or ask a Health & Social Care Professional for a paper copy. Also consider contacting Herts Help who can advise you , for example getting a personal alarm

*Unless you are on a fluid restriction as advised by your healthcare professional

For tips and details on how you can prevent falls, please read the Getup and Go leaflet, you can find this online or ask a Health & Social Care Professional for a paper copy

Back to pathway

Self-management information

The following actions can be completed by any professionals involved in the person's care:

Signpost to:

- **Get up and Go** leaflet: http://www.csp.org.uk/publications/get-go-guide-staying-steady
- Consider giving STP Ageing Well resource pack
- Regular sight and hearing checks
- Health promotion advice
- Technology innovations e.g. pendant alarms, telehealth care solutions (may be eligible for council schemes)

Raise awareness of:

- Eating well and staying hydrated - https://www.nhs.uk/conditions/dehydration/
- Home hazards and wearing the correct footwear
- Skin health – recommend regular moisturising
- What to do if the person has a fall – see Get up and Go leaflet for more information
- Local and National campaigns that occur at different times of the year e.g. Slipper's Swap campaign
- Appropriate foot care
- Staying active

Further assessment (as appropriate):

- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see Identification of Frailty pathway)
- Carers assessment as appropriate – refer to appropriate service
- Postural hypotension assessment
- Safe and well fire service checks

Health and Social Care professionals to consider social prescribing and assessing loneliness as appropriate

Social prescribing

- Signpost to voluntary/third sector for support (e.g. HILS, Age UK)
- Promote the concept of the patient volunteering (helps loneliness wellbeing, physical activity) – signpost/ help to find opportunities to volunteer
- Advice on keeping warm
- Signpost to social opportunities (e.g. lunch clubs, local older people's groups, digital inclusion)
- Signpost to physical activities opportunities – consider exercise on referral and falls prevention
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The scale generally uses three response categories: **Hardly ever / Some of the time / Often**

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In order to score somebody's answers, their responses should be coded as follows:
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The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.
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Back to pathway

Exercise – strength and balance

Exercise is an important part of falls risk reduction, however certain health conditions and individual fitness levels need to be considered before making a recommendation to exercise. The contraindications outlined* indicate some of the conditions to be aware of, however, if in doubt, recommend the person seeks health professional advice before commencing a new exercise programme.
Anyone recommending exercise should give the following advice:
Make sure that any exercise classes, or exercises described in guides or videos, are suitable for you and that you feel comfortable doing the exercises. If you're not sure, or if you have a heart condition or haven't been exercising regularly, speak to your healthcare professional first about what activities may best suit you.

If you experience chest pain or feel faint whilst exercising, stop exercising immediately and contact your healthcare professional. If you feel very unwell, for example chest pain does not subside on resting - call 999.

If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.

Unless clinically contraindicated* recommend:

- Lifelong approach to exercise
- Minimum of 2 times per week
- Balance and coordination exercise at least 2 days a week

Please see Hertfordshire exercise matrix for recommendations according to risk (INSERT LINK)

Recommended activities:

- Exercise continuum based on identified need:
  - Individualised self-management
  - Tai Chi, positive movement and older peoples exercise class
  - Long-Term Conditions specific classes
  - OTAGO**/ Postural stability classes
- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex) for local exercise opportunities

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There are also several absolute contra-indications to exercise which referring health professionals should be familiar with, see list below[xi]. Patients with absolute contraindications should not exercise until such conditions are stabilised or adequately treated.

Absolute contra-indications to exercise:

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- Symptomatic severe aortic stenosis
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- Uncontrolled / unstable angina
- Acute uncontrolled psychiatric illness
- New or uncontrolled arrhythmias
- Experiences significant drop in BP during exercise
- Uncontrolled resting tachycardia ≥ 100 bpm
- Febrile illness
- Experiences pain, dizziness or excessive breathlessness during exertion
- Any unstable, uncontrolled condition[xiii]

[xii] Appropriate guidance on this should be provided either by the patient's cardiologist or cardiac rehabilitation team
[xiii] Diabetes may be an exception here as exercise can help individuals' in the management of uncontrolled Diabetes

High risk

Refer patients categorised as high risk in the risk stratification to appropriate supervised physical activity

Factors
- Cardiac - Stable angina with no chest pain at rest, myocardial infarction, coronary artery bypass graft, valve replacement, pacemaker, percutaneous transluminal coronary angioplasty, heart failure
- Cardiac arrhythmias - diagnosed by cardiologist
- Hypertension - medicated but with BP of 160–180/ 95–100 mmHg
- Transient ischaemic attack - with severe disability/cognitive impairment
- Older people > 65 years at risk of falls - has fallen within the last 12 months
- Osteoporosis - BMD T score > 2.5 SD
- Claudication - with cardiac dysfunction
- Type 1 or 2 diabetes - with accompanying autonomic neuropathy, advanced retinopathy
- Severe osteoarthritis/rheumatoid arthritis - with associated immobility
- Moderate to severe asthma - where ventilatory limitation restrains sub-maximal exercise
- COPD/emphysema - with true ventilatory limitation
- Severe psychiatric illness - cognitive impairment, dementia, schizophrenia
- AIDS - with accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection

** An evidence-based exercise programme to improve balance, muscle strength, general fitness and well-being

Please follow **hyperlink** for PDF version with active links

Falls framework for postural stability and exercise in Hertfordshire

	No immediate risk / Low risk of falls	Low – moderate risk of falls	Moderate-high risk of falls
Descriptor	• Over the age of 65- no history or immediate risk of falls identified. Not yet fallen • Scores 0 on the Falls Risk Assessment Tool (FRAT)	• Mild deficit in strength and balance. No more than 1 fall in last 12 months. Reduced confidence Judged at low risk of recurrent falls • Score 1-2 on the Falls Risk Assessment Tool (FRAT)	• Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk Mild deficit in strength and balance plus cognitive/ motivational issue • Score 3 and above on the Falls Risk Assessment Tool (FRAT)
Assessment Options	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) (optional) • Multifactorial assessment (optional)	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) • Multifactorial assessment
Who could refer	All	All	GP/ Health and Social Care Professionals/ Other community providers
Activity	• Self-management & advice • Signpost to Herts Help for local exercise opportunities • Signpost to the Get up and go exercise advice (leaflet/online) • General exercise classes and physical activity through public, private, voluntary & third sector exercise providers, e.g. Tai Chi	Exercise continuum based on identified need: • Individualised self-management • Tai Chi, positive movement and older peoples exercise class • Long-Term Conditions specific classes • OTAGO*/ Postural stability classes	Exercise continuum based on identified need: • Individualised Self-management programme • Individualised strength and mobility exercises if unable to begin balance exercises / PSI/OTAGO • Community OTAGO/ Postural Stability class • Home-based OTAGO programme • Home-based Physio/OT
Time	• Regular lifelong approach to exercise • 150 minute of moderate activity per week • Strength exercises on two or more days	• Lifelong approach to exercise • Minimum of 2 times per week • Balance and coordination exercise at least 2 days a week	• 50 hours (3 hours per week - 1-hour class + 2 hours independently) Arrangements for maintaining and review post course completion • Recommendation can depend on the individual needs, capacity & ability • Lifelong approach to exercise

* An evidence based exercise programme to improve balance, muscle strength, general fitness and well-being

Back to pathway

Moderate – high risk

For example (one or more of the following dependant on how many assessments are carried out):

- Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk
- Mild deficit in strength and balance plus cognitive/ motivational issue
- Score 3 or above on the Falls Risk Assessment Tool (FRAT)
- >12 seconds result on Timed up and Go (TUG)
- Indication of postural hypotension
- Concerns about person's falls risk
- Indication of mild, moderate or severe frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.

Back to pathway

Community falls and frailty hub to co-ordinate pathways – to include co-ordination of Clinical Multifactorial Assessment (MFA)

Multi-factorial assessment by multidisciplinary clinical team in community e.g. Physiotherapists, Occupational Therapists, GPs, Geriatricians including support when required from other professionals such as Pharmacists, Opticians etc.

The MFA should be co-ordinated by the falls and frailty hub who should send the right person/people to complete any assessments and plan the next steps.

Discuss with patient

- Falls history
- Perceived functional ability/fear of falling
- Osteoporosis risk factors/assess risk
- Urinary symptoms and continence
- Dizziness or light-headedness
- Levels of physical activity

Examine the patient

- Gait, balance and mobility, and muscle weakness
- Neurological examination and cognition
- Cardiovascular examination including postural blood pressure
- Vision and hearing
- Skin health/Tissue viability

Review contributory factors

- Medication review
- Home hazards and footwear
- Nutrition and hydration
- Long-term conditions and co-morbidities
- Foot care

Medical Intervention

If the risk of falls for an individual is felt to be due to medical issues (for example: postural hypotension or medication issues), the hub should consider onward referral e.g. pharmacist or GP, or a specialist review (secondary care) for highly complex patients.

Back to pathway

Manage identified risk factors

This needs to be completed by a clinician. However, the interventions may be completed by more than one clinician involved in the person's care.

Multifactorial interventions
All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

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

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal

Back to pathway

Exercise – strength and balance

As part of the clinical assessment, the patient should be risk stratified for their safety to exercise

Absolute contra-indications to exercise:

- A recent significant change in a resting ECG, recent myocardial infarction or other acute cardiac event[xii]
- Symptomatic severe aortic stenosis
- Acute myocarditis or pericarditis
- Resting Systolic Blood Pressure ≥ 180mmHg / DBP ≥ 100mmHg
- Uncontrolled / unstable angina
- Acute uncontrolled psychiatric illness
- New or uncontrolled arrhythmias
- Experiences significant drop in BP during exercise
- Uncontrolled resting tachycardia ≥ 100 bpm
- Febrile illness
- Experiences pain, dizziness or excessive breathlessness during exertion
- Any unstable, uncontrolled condition[xiii]

[xii] Appropriate guidance on this should be provided either by the patient's cardiologist or cardiac rehabilitation team
[xiii] Diabetes may be an exception here as exercise can help individuals' in the management of uncontrolled Diabetes

If the patient is at high risk* of exercise, consider specific intervention

If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.

Unless clinically contraindicated recommend:

- 50 hours (3 hours per week - 1-hour class + 2 hours independently). Arrangements for maintaining and review post course completion
- Recommendation can depend on the individual needs, capacity & ability
- Lifelong approach to exercise

Recommended activities:

- Exercise continuum based on identified need:
  - Individualised Self-management programme
  - Individualised strength and mobility exercises if unable to begin balance exercises / PSI/OTAGO
  - Community OTAGO/ Postural Stability class
  - Home-based OTAGO programme
  - Home-based Physio/OT
- Signpost to NHS livewell - exercise for older adults: https://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-older-adults.aspx
- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex) for local exercise opportunities

HertsHelp: https://www.hertshelp.net/hertshelp.aspx

Contact us
Phone: 0300 123 4044
Email: info@hertshelp.net
Skype: HertsHelp
Text: hertshelp to 81025
Minicom: 0300 456 2364
Fax: 0300 456 2365
BSL: https://www.signbsl.com/

Living Well Essex: https://www.livingwellessex.org/

Contact us
Phone: 03457 430 430 or 01245 430 430
Textphone: 0345 758 5592
Email: contact@essex.gov.uk
Opening hours are 8.30am-5pm Monday to Friday.
Other information about health and care services available: *Healthwatch Essex Information Service* on 0300 500 1895.

***High risk**

Refer patients categorised as high risk in the risk stratification to appropriate supervised physical activity

Factors

- Cardiac - Stable angina with no chest pain at rest, myocardial infarction, coronary artery bypass graft, valve replacement, pacemaker, percutaneous transluminal coronary angioplasty, heart failure
- Cardiac arrhythmias - diagnosed by cardiologist
- Hypertension - medicated but with BP of 160–180/ 95–100 mmHg
- Transient ischaemic attack - with severe disability/cognitive impairment
- Older people > 65 years at risk of falls - has fallen within the last 12 months
- Osteoporosis - BMD T score > 2.5 SD
- Claudication - with cardiac dysfunction
- Type 1 or 2 diabetes - with accompanying autonomic neuropathy, advanced retinopathy
- Severe osteoarthritis/rheumatoid arthritis - with associated immobility
- Moderate to severe asthma - where ventilatory limitation restrains sub-maximal exercise
- COPD/emphysema - with true ventilatory limitation
- Severe psychiatric illness - cognitive impairment, dementia, schizophrenia
- AIDS - with accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection

Please follow **hyperlink** for PDF version with active links

Falls framework for postural stability and exercise in Hertfordshire

	No immediate risk / Low risk of falls	Low – moderate risk of falls	Moderate-high risk of falls
Descriptor	• Over the age of 65- no history or immediate risk of falls identified. Not yet fallen • Scores 0 on the Falls Risk Assessment Tool (FRAT)	• Mild deficit in strength and balance. No more than 1 fall in last 12 months. Reduced confidence Judged at low risk of recurrent falls • Score 1-2 on the Falls Risk Assessment Tool (FRAT)	• Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk Mild deficit in strength and balance plus cognitive/ motivational issue • Score 3 and above on the Falls Risk Assessment Tool (FRAT)
Assessment Options	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) (optional) • Multifactorial assessment (optional)	• FRAT • Your step-by-step guide to staying independent and preventing falls in Hertfordshire • Quantitative Timed Up and Go (QTUG™) / Timed Up and GO (TUAG) • Multifactorial assessment
Who could refer	All	All	GP/ Health and Social Care Professionals/ Other community providers
Activity	• Self-management & advice • Signpost to Herts Help for local exercise opportunities • Signpost to the Get up and go exercise advice (leaflet/online) • General exercise classes and physical activity through public, private, voluntary & third sector exercise providers, e.g. Tai Chi	Exercise continuum based on identified need: • Individualised self-management • Tai Chi, positive movement and older peoples exercise class • Long-Term Conditions specific classes • OTAGO*/ Postural stability classes	Exercise continuum based on identified need: • Individualised Self-management programme • Individualised strength and mobility exercises if unable to begin balance exercises / PSI/OTAGO • Community OTAGO/ Postural Stability class • Home-based OTAGO programme • Home-based Physio/OT
Time	• Regular lifelong approach to exercise • 150 minute of moderate activity per week • Strength exercises on two or more days	• Lifelong approach to exercise • Minimum of 2 times per week • Balance and coordination exercise at least 2 days a week	• 50 hours (3 hours per week - 1-hour class + 2 hours independently) Arrangements for maintaining and review post course completion • Recommendation can depend on the individual needs, capacity & ability • Lifelong approach to exercise

* An evidence based exercise programme to improve balance, muscle strength, general fitness and well-being

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Self-management advice and care planning

The following actions can be completed by any professionals involved in the person's care:

Care planning information

- Discuss individuals interests and priorities
- Signpost to community organisations relevant to persons' preferences including exercise opportunities
- Use STP care plan documentation – start / maintain / update as appropriate
- Identify informal carers and record on clinical record and patient held care plan
- Agree self-management goals and actions with person if appropriate

Self-management information

Signpost/refer to:

- STP Ageing Well resource pack (this will include Get up and Go leaflet: http://www.csp.org.uk/publications/get-go-guide-staying-steady)
- **Your step-by-step guide to staying independent and preventing falls (Hertfordshire) INSERT LINK –** this is a local guide to health and social care resources that can help people stay independent
- Technology innovations e.g. pendant alarms, telehealth care solutions (may be eligible for council schemes)
- Consider Anxiety and if required signpost to local Wellbeing Service

Raise awareness of:

- Eating well and staying hydrated - https://www.nhs.uk/conditions/dehydration/
- Home hazards and wearing the correct footwear
- Skin health – recommend regular moisturising
- What to do if the person has a fall – see Get up and Go leaflet for more information
- Local and National campaigns that occur at different times of the year e.g. Slipper's Swap campaign
- Appropriate foot care
- Staying active

Further assessment (as appropriate):

- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see *Identification of Frailty* pathway)
- Postural hypotension assessment
- Cognitive assessment
- Carers assessment – refer to appropriate service
- Home environment assessment for aids/adaptations and equipment
- Safe and well fire service checks

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Imminent risk

Immediate risks/acutely unwell:

- Manage any immediate risks within your capability and competence.
- Escalate any concerns

If not in immediate danger requiring urgent review then ALL people should be referred for a clinical multi-factorial risk assessment.

If the person is identified as high risk of falls (high score on the FRAT or clinical concerns), they should be referred to Community Trust (predominantly mobility and balance concerns) or their GP (predominantly medical concerns e.g. condition specific, medication).

If a falls and frailty hub is available, the person should be referred there to be appropriately triaged for ongoing management.

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Information for care homes

- Individuals living in care homes and other residential settings, should have equal access and opportunity to all risk tools and assessments (as appropriate for them).
- If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.
- For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present.
- Presence of additional needs should not be a barrier to assessing a person for frailty or falls.
- Contact local Care Providers association for details of local support and training packages available e.g. Hertfordshire Care Providers Association has launched the Stop Falls Campaign for Health and Social care staff across Hertfordshire, funded by Hertfordshire County Council. The campaign aims to increase knowledge on minimising risk and understanding how to asses clients at risk of falls in social care settings, by upskilling staff through education and our 'Top Tip' Resource packs. To view our materials visit www.hcpa.info/stopfall<http://www.hcpa.info/stopfall