12.08 A Day in the Life of Community Falls Teams

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Learning outcomes:

Knowledge:

- To know the professionals who may make up a community 'falls team'
- To know some of the key assessments and interventions a falls team assessment may utilise.

Skills:

- To know the information falls teams may require when receiving a referral

Attitudes:

- Consider how we complete referrals to provide onward teams with an appropriate amount of information which avoiding information duplication.

Social Media

Paper of the Week

Paper available here

Myrsep A and D Thomson. 2018. Housebound patients' experiences of a falls service provided by a team of community physiotherapists.
International Journal of Therapy and Rehabilitation, 2018. Vol 25, Iss 12.

- Qualitative descriptive approach to evaluate falls service
- 'to encapsulate the thoughts, beliefs and feelings of the recipients of this service'.
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- Drawn from sample referred by GP, purposeful sampling – to select individuals who were able to purposefully inform an understanding of the research question.

6 housebound participants.

- Interviewed 45 min in own homes using open questions, with probing, rephrasing and summarising, transcripts reviewed by the participants.
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inductive process of analysis, thematic analysis

- Generated 4 main themes- the falls, the physiotherapy service, exercise and outcome of the service.
- Included final theme map in article

The Falls

The level of concern about falling among the participants did not consistently match their apparent level of function.

The Physiotherapy Service

- Although some were aware that the physiotherapist was visiting because they had fallen over, nobody mentioned that one purpose was to improve their balance.

Exercise

- Exercises included leg strengthening exercises and balance exercises that are in accordance with NICE (2013) guidelines.
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- All the participants believed that exercising was beneficial and can help with movement and reduce pain. One of the participants believed that exercise had to be done regularly for it to be beneficial.

The outcome of the service

They participants said they appreciated the support that the service offered and some achieved improved movement. One participant who had been bedbound was able to walk in his flat and another said his walking had improved.

Demonstrates improvements in patient outcomes from community physiotherapy services but care is fragmented and often other risk factors not addressed – clinicians need to consider whole picture.

Recommend an MDT approach for this client group- like the Frailty Teams we met in episode 12.5!

The authors suggest people who have fallen should be able to refer or re refer themselves to services- suggest improves Service user – Service provider relationship, autonomy and possible improved outcomes.

In order to identify patients who may benefit from falls referral and assessment NICE guidance recommends that all health professionals proactively ask patients about falls at all interactions.

Previous research has shown that participants felt that falls were an inevitable part of ageing and could not be avoided. They were also worried about the consequences of falls, and many did not report falls to health professionals despite being at risk of severe falls in the future. So by asking people about falls we have the opportunity to show them falls can be prevented, are not just an expected part of ageing and provide patients opportunities for referral.

FRAX score, which estimates the 10 year risk of osteoporotic fracture. Factors that the score includes are country of residence, age, sex, race, weight, height, BMI, history of fragility fracture, family histroy of osteoporosis, current smoking history, corticosteroid use, rheumatoid arthritis, secondary osteoporosis and alcohol use.

If using an online calculator the output will be the percentage risk of fracture in 10 years. The national osteoporosis guideline group recommends both supplementation of calcium and vitamin D, and also strongly recommends strength and balance training to those identified to be at risk of falls.
By doing this assessment, teams can identify those who might need a GP to prescribe medications and also who may benefit from referral to local strength and balance classes that the team provide.

Non-Pharmacological management of osteoporosis
FRAX intervention thresholds

HOME Fast Assessment is a screening tool to help those assessing people in their homes to identify key risk factors.

Falls efficacy scale is a scoring tool to help us quantitatively assess a persons fear of falling. Falls self efficacy refers to personal beliefs in one's ability to engage in certain activities of daily living without falling or losing balance. fear of falling may be an important barrier to consider, as it is associated with distress, increased use of medication, decreased physical function, increased risk of falls, reduced quality of life, activity restrictions, fractures, and admission to institutional care.

Falls efficacy scale

Sometimes seeing someone in their own home as opposed to a clinical environment can help professionals assessing them see how people really move and behave which might help us identify risk factors for falling we might not have seen before. Work by Morrow, Markivics and Harris identified that assessment in the patients own home enabled faster identification of the mechanism of a fall. Advance physiotherapy practitioners delivering home assessment to patients reduced the referral to Geriatricians, and although the rate of readmission with falls increased the number of fractures reduced. The wait time to be reviewed also reduced from 69 days to 20 days.

There's obviously pros and cons to this approach, and it would be beneficial to know the full range of assessments used by these teams, but reducing the time to assessment is likely to be beneficial as is the benefit of assessment at home. However I read this and thought that maybe its not necessarily benefit to reduce referrals to geriatricians globally and we need to evidence we're reducing 'inappropriate' referrals?

Morrow. Markivics and Harris Poster Presentation, 2022. Pg 13.

What information should we include when making a referral to Falls Team services?

Type of accommodation, number of stairs, is there a lift or stair-lift?
Does the person live alone? If no- who do they live with?
What is property access like? Are there steps, a key safe or care line button?
Has the person had previous fractures? Do they have hearing or vision impairment?
Does the person go outside or are they housebound?
Do they drink alcohol or smoke?
Do they take more than 4-6 medications per day?
What is their medical history do they have any conditions that may increase their risk of falls such as stroke,, Parkinsons or MS?

Do they have any history or low mood, depression or loneliness which might impact their self efficacy?
Overall when referring your patients it is useful to take the time to complete referral documents thoroughly to ensure we're providing the onward teams with sufficient information to make decisions regarding prioritising patients and start considering interventions that might be suitable.

Curriculum Mapping

NHS Key Skills Framework	Core	Communication 2:	Communicate with a range of people on a range of matters
		Personal and People development:	Contribute to own personal development
		Quality	Maintain the quality of own work
	Health and Wellbeing	HWB4 Level 2	Enable people to meet ongoing health and wellbeing needs.
		HWB4 Level 3	Plan , deliver and evaluate care to meet peoples health and wellbeing needs
Foundation training Curriculum	Foundation Year 1	Section 2.6 Interface with HCPs	Describes the structure and importance of the wider healthcare team Works effectively within the healthcare team for the benefit of patient care Makes clear, concise and timely written and oral referrals to other healthcare professionals within the hospital
		Section 2.7 Interaction with Collegues	Acts as a member of the multidisciplinary professional team by supporting, respecting and being receptive to the views of other healthcare professionals Works effectively with others towards a common goal e.g. accepts instructions and allocation of tasks from seniors at handovers and multidisciplinary team meetings

		Section 4:20 Healthcare resource management	Demonstrates understanding of the organisational structure of the NHS and independent sector and their role in the wider health and social care landscape Describes hospital and departmental management structure
	Foundation Year 2	Section 2.6 Interface with other healthcare professionals Section 2.7 Interaction with Colleagues	Demonstrates ability to make referrals across boundaries / through networks of care (primary, secondary, tertiary) Demonstrates initiative e.g. by recognising work pressures on others, providing support and organising / allocating work to optimise effectiveness within the clinical team
		Section 2.7: continuity of care/ Interaction with colleagues	
GP training Curriculum		Clinical management Managing complex and long term care Working with colleagues and in teams	Contribute to an organisational and professional approach that facilitates continuity of care (e.g. through adequate record keeping and building long term patient relationships) Organise follow up of your patients after referral through multiprofessional, team bases and structured approaches including monitoring, reviewing and regular care planning. Demonstrate the ability to effectively 'navigate' patients with multiple problems along and between care pathways, enabling them to access appropriate team members and services in a timely and cost-effective manner. Enhance working relationships by demonstrating understanding, giving effective feedback and maintaining trust. Appropriately seek advice from other professionals and team members according to their roles and expertise.

		Working well in organisations and systems of care Organisation, management and leadership Community orientation	Show commitment to a process of continuing professional development through critical reflection and addressing of learning needs. Recognise the importance of distributed leadership within health organisations, which places responsibility on every team member and values the contribution of the whole team Describe the current structure of your local healthcare system, including various role, responsibilities and organisations within it, applying this understanding to improve the quality and safety of care you provide.
Core medical training curriculum		Managing long term conditions and promoting patient self care:	Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care Recognise importance of multi-disciplinary assessment Contribute to effective multi-disciplinary discharge planning
Internal medicine training curriculum (Stage 1)		Cat 2.3 . Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	Communicates effectively with clinical and other professional colleagues Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
Geriatrics and higher specialty training curriculum			Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care

		30: Rehabilitation and Multidisciplinary team working 31: Planning transfers of Care including discharge	Roles and expertise of different members of interdisciplinary team Physical therapies which improve muscle strength and function Therapeutic techniques/training to improve balance and gait Aids and appliances which reduce disability. Understand the structure, roles and responsibilities of the multi-disciplinary team including the importance of outside agencies, and the way in which individual behaviours can impact on a group Role of the geriatrician and the multidisciplinary team in discharge planning