

STAYING ACTIVE, REDUCING AND MANAGING FALLS

IN CARE HOMES

WITH THE MULTI-DISCIPLINARY TEAM OVER
VIDEO CONFERENCING

Jo Gordon, Community Falls Coordinator, Long Term Conditions Programme, EHSCP

ACKNOWLEDGEMENTS



- Amy Taylor, Project Support Officer, Long Term Conditions Programme
- Amanda Fox, Programme Manager, Long Term Conditions Programme
- Ricky Samson, Manager, NHS Lothian Quality Improvement
- Staff and individuals in 9 care homes in Edinburgh
- Numerous specialist practitioners including Cathy Findlay, Shona Bellward, Kelly Russell, Suzanne Crooks, Margaret Shaw, Heather Bainbridge and Avril Brown

THE SITUATION

- During the infection control restrictions on care homes in 2020, concern was growing
- Many previously active and less dependent individuals were restricted to their rooms
- Group activities were cancelled
- Specialist support services were unable to enter the care homes
- Deconditioning alongside an increased risk of falls
- Reduced specialist input and management of individual needs
- Increased concerns around hospital attendances or admissions
- Care home residents are 3x more likely to fall than older people living in the community
- 10% of those who fall sustain a fracture



THE AIM



- To respond to these pandemic challenges making use of Near Me video conferencing
- To acknowledge the reduced physical activity and potentially increased falls risk relating to pandemic restrictions
- To provide responsive, coordinated, care home focused multi-factorial and multi-disciplinary support
- To create a flexible project design, that asked little from care homes in terms of requirements and data collection
- To draw upon and where relevant bring together all available local knowledge and expertise

THE DESIGN AND PREPARATION



- Attended virtual training on the secure Near Me platform
- Secured a Near Me 'waiting room'
- Developed a guide for promoting physical activity, reducing and managing falls in care homes
- Developed project documents, standard emails, and attachments explaining Near Me
- Promotion of the service through care home channels, professional networks and the Edinburgh Health and Social Care Partnership daily staff updates
- Launched the trial improvement service in May 2020 for 6 months

DELIVERY

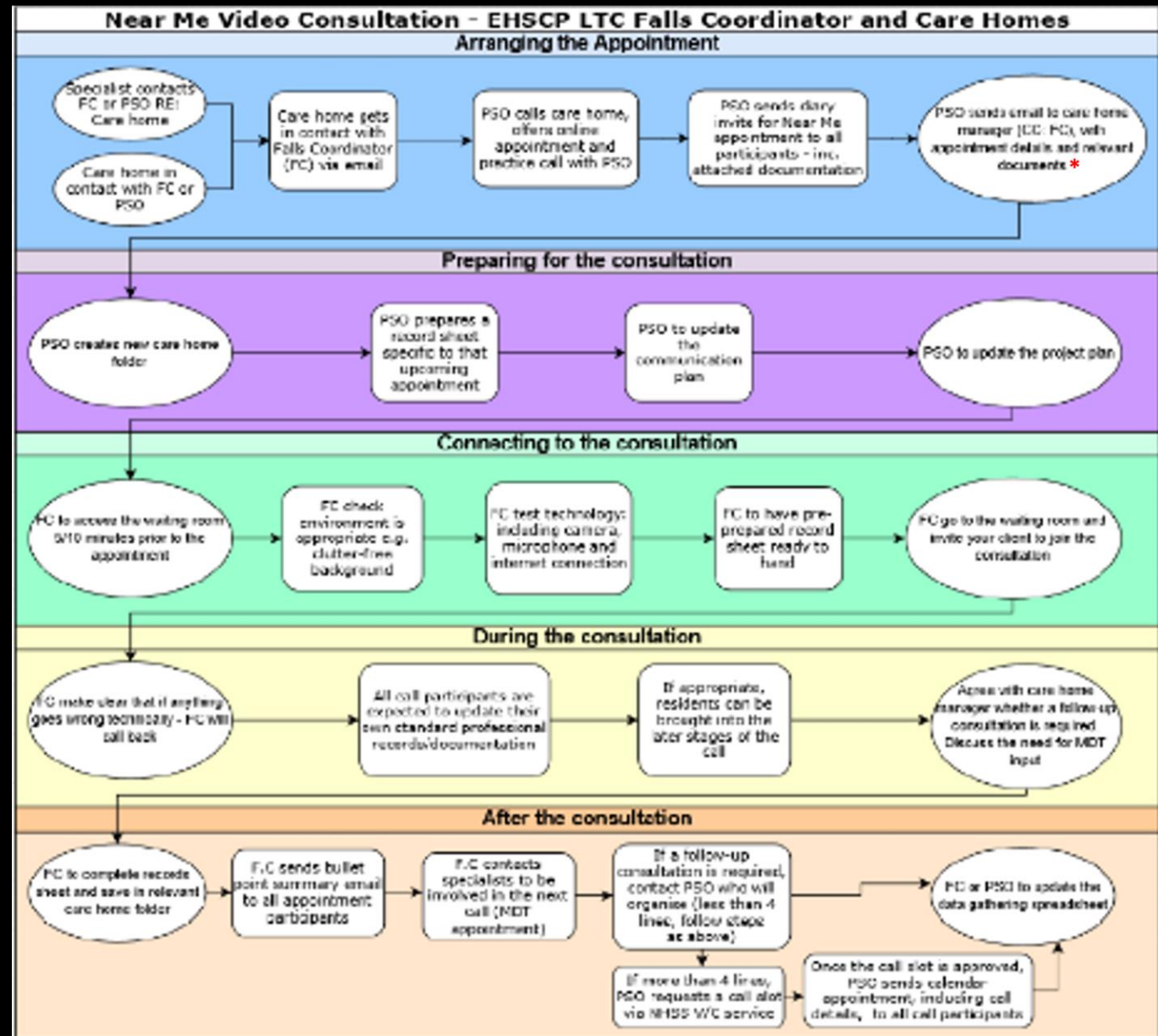
Key:

FC – Falls Coordinator

PSO – Project Support Officer

Attached documentation included:

1. Care home information leaflet
2. Near Me Resources for Care Homes – from Scottish Care Inspectorate
3. Staying Active and Reducing Falls in Edinburgh Care Homes



DELIVERY

Attending your appointment via video

EHSCP LTCP Community Falls Coordinators

Where appropriate, you can attend your consultation online via a video call.

Video calling is as convenient as a phone call, with the added value of face-to-face communication.

It can save you time and money, and brings your care closer to home.



Where do I go to attend my appointment?

Go to: <https://nhsattend.vc/elcfc>

Instead of travelling to your appointment, you enter the clinic's online waiting area. The health service is notified when you arrive, and your clinician will join you when ready.

There is no need to create an account. No information you enter is stored.

Is it secure?
Video calls are secure; your privacy is protected.
You have your own private video room that only authorised clinicians can enter.

How much internet data will I use?
You don't use any data while waiting for a clinician to join you.
An Attend Anywhere video call uses a similar amount of data to Skype® or FaceTime®.

How much does a video call cost?
The video call is free (except for your internet usage).

What do I need to make a video call?

- ✓ A good connection to the internet. If you can watch a video online (e.g. YouTube) you can make a video call.
- ✓ A private, well-lit area where you will not be disturbed during the consultation.
- ✓ One of these:
 - Google Chrome web browser on a desktop or laptop, or on an Android tablet or smartphone
 - Safari web browser on an Apple iMac, MacBook, iPad, or iPhone
- ✓ Web-camera, speakers and microphone already built into laptops or mobile devices.

Smartphone and tablet users
If you can, connect to a home or work Wi-Fi network to avoid using your mobile data allowance.

See over for more information on how to make a video call

Staying active and reducing the risk of falls in Edinburgh care homes during COVID-19

A message for care home managers and staff

This guide gives you advice on how to support residents to stay active, reduce and manage falls during COVID-19 restrictions, and offers suggestions, whether your care home is [physical distancing or shielding](#) residents.

Staying active

Physical activity for residents can be a challenge to maintain during COVID-19 restrictions, but it is important for health and function for residents to stay active.


While some residents may be able, with encouragement and resources, to exercise independently, many may require supervision and some may need assistance.


Physical distancing means that all residents and staff remain 2 metres apart, but it is still possible for them to enjoy physical activity in the care home and grounds.


Shielding of residents means they may need to remain in their rooms but, with planning, staff can support individual residents to be physically active.


Some tips for staying safe when staying active:

- Consider safety and the abilities of the resident, choosing activities they enjoy. Remember all day to day resident activities [count](#).
- For residents who are not regularly active, start slowly with very low intensity activities, for a short time, ensuring they can breathe comfortably [throughout](#).
- If a resident is unwell with a cough, fever or difficulty breathing they should rest, not be physically active, and you should follow [advice](#).
- Remember to follow all hand hygiene and personal protective equipment (PPE) recommendations if working with residents at the same time, or one after the other.
- Ensure areas used for physical activity are free from clutter, and follow guidance for cleaning surfaces, objects and the environment after sessions. Suggestions below:

 FallsAssistant • NHS-approved graded exercise sessions for [improving strength and balance](#) on Falls Assistant website, with a check to see which level is best

 laterLife training • 3 x daily 10 minute [seated and standing exercise](#) videos during COVID-19 by Later Life Training: evidence-based classes at 8am, 12noon, 4pm on YouTube

 NHS • NHS has developed [seated exercises](#) suitable for many residents with a helpful pdf you can download and print

 care inspectorate • Resources from the Care Inspectorate's Care About Physical Activity (CAPA) programme to [help residents stay active](#)

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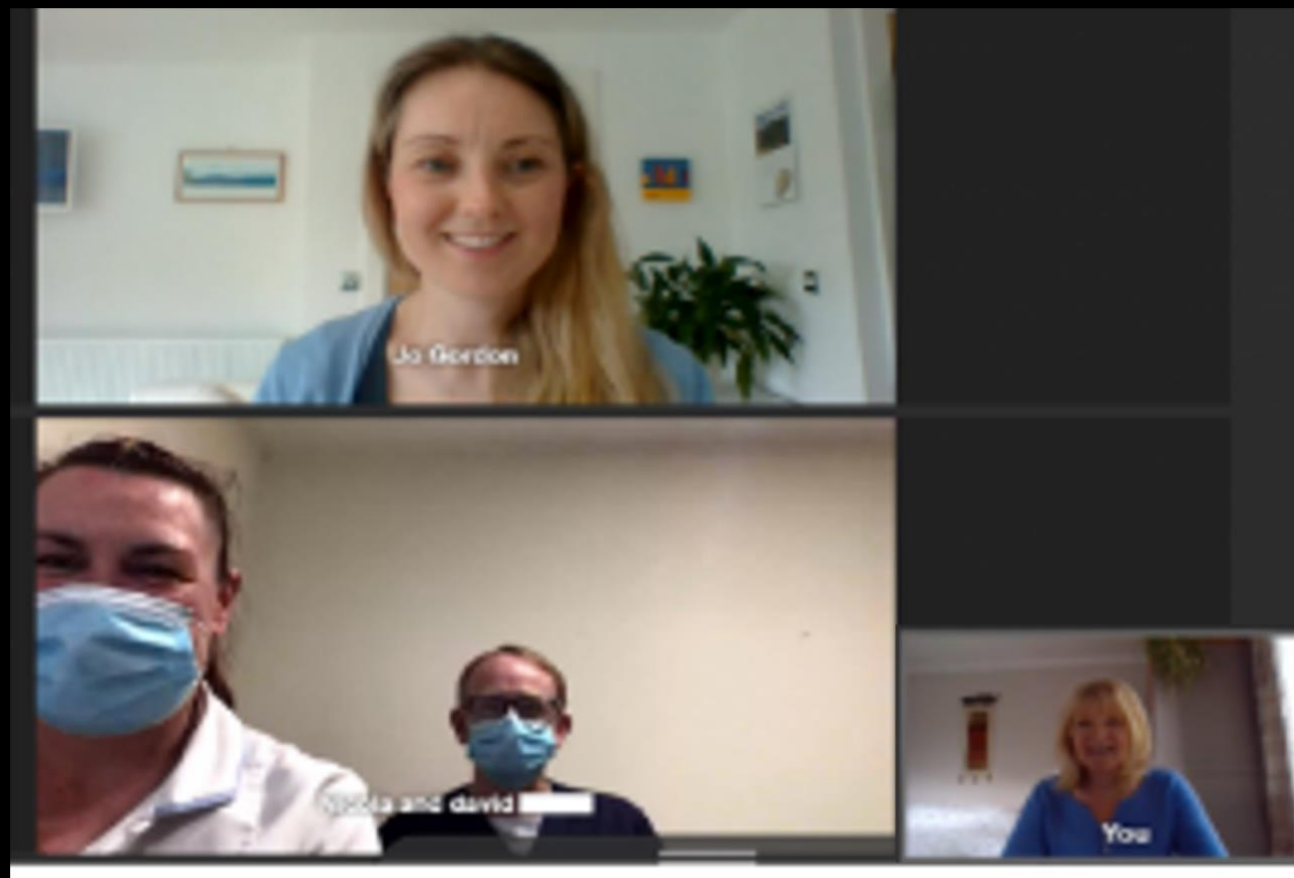
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DELIVERY

Screenshot from
Near Me



DELIVERY

Name: _____ Date: _____
 Role: _____ Care Home: _____

Edinburgh Health and Social Care Partnership

Staying active, reducing and managing falls- Care home support service

Questions
 On a scale of 1 to 5, please consider the following questions regarding your experience with the care home support service, using the Near Me video appointment platform.

	1	2	3	4	5
Did the staying active, reducing and managing falls care home support service meet your expectations?	☹️		😊		😄
Did the Near Me video appointment platform used for this purpose, meet your expectations?					

What did you find beneficial about the staying active, reducing and managing falls care home support service?

What about this service could have been better?

What did you find beneficial about the Near Me video appointment platform used for this purpose?

What about this platform could have been better?

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Name: _____ Date: _____
 Role: _____ Care Home: _____

Edinburgh Health and Social Care Partnership

Considering a key resident and falls frequency, from your records, please could you give the following values?

Number of falls per week on average, before taking part in the project	
Number of falls per week on average, after completing the project	

Last question:
 Where possible, considering another key resident and falls frequency, from your records, please could you give the following values?

Number of falls per week on average, before taking part in the project	
Number of falls per week on average, after completing the project	

Thank you for taking part in this survey

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Name: _____ Date: _____
 Role: _____ Team: _____

Edinburgh Health and Social Care Partnership

Staying active, reducing and managing falls - Care home support service

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	1	2	3	4	5
Did the staying active, reducing and managing falls care home support service meet your expectations?	☹️		😊		😄
Did the Near Me video appointment platform used for this purpose, meet your expectations?					

1a) What did you find beneficial about the staying active, reducing and managing falls care home support service?

1b) What about this service could have been better?

2a) What did you find beneficial about the Near Me video appointment platform used for this purpose?

2b) What about this platform could have been better?

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Name: _____ Date: _____
 Role: _____ Team: _____

Edinburgh Health and Social Care Partnership

3a) Do you think this approach has potentially saved you as a clinician, or your team, time or has it cost more?

3b) If you feel that this project has saved you or your team time, per care home, per resident or per appointment, how would you quantify it?

3c) Other than clinician time, has it saved on any other costs? If so, please describe.

4) Do you feel that this approach has improved or disadvantaged the quality of care for residents?

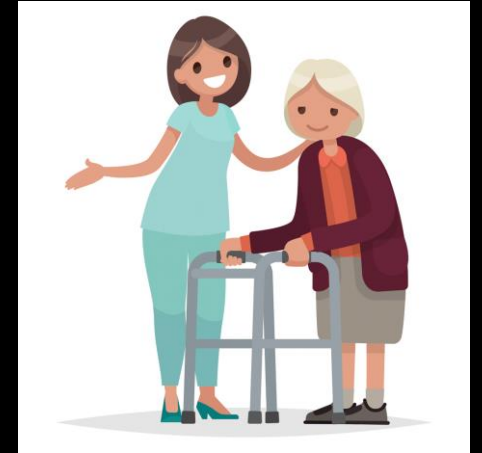
5) Considering current time during the COVID-19 pandemic, do you feel there are any other benefits of this approach?

Thank you for taking part in this survey

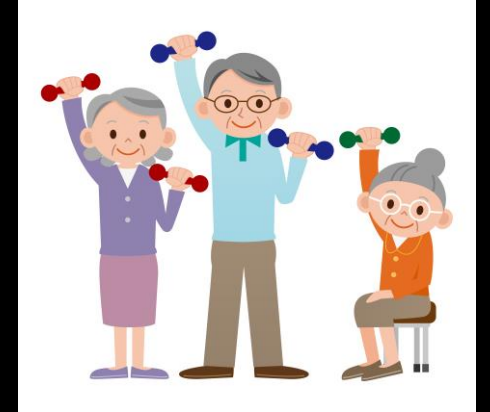
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SUMMARY OF RESULTS

- 9 care homes participated
- All discussed the whole care home or a whole unit, with 2 just that
- 7 discussed 1 or more individuals some more than 1 individuals with the largest number being 5
- Some had 1 call, some more than 1, the most being 4
- Care home feedback forms included number of falls per week pre and post input for each resident involved
- All managers gave feedback on the service and the platform
- All supporting practitioners gave feedback on the service and the platform

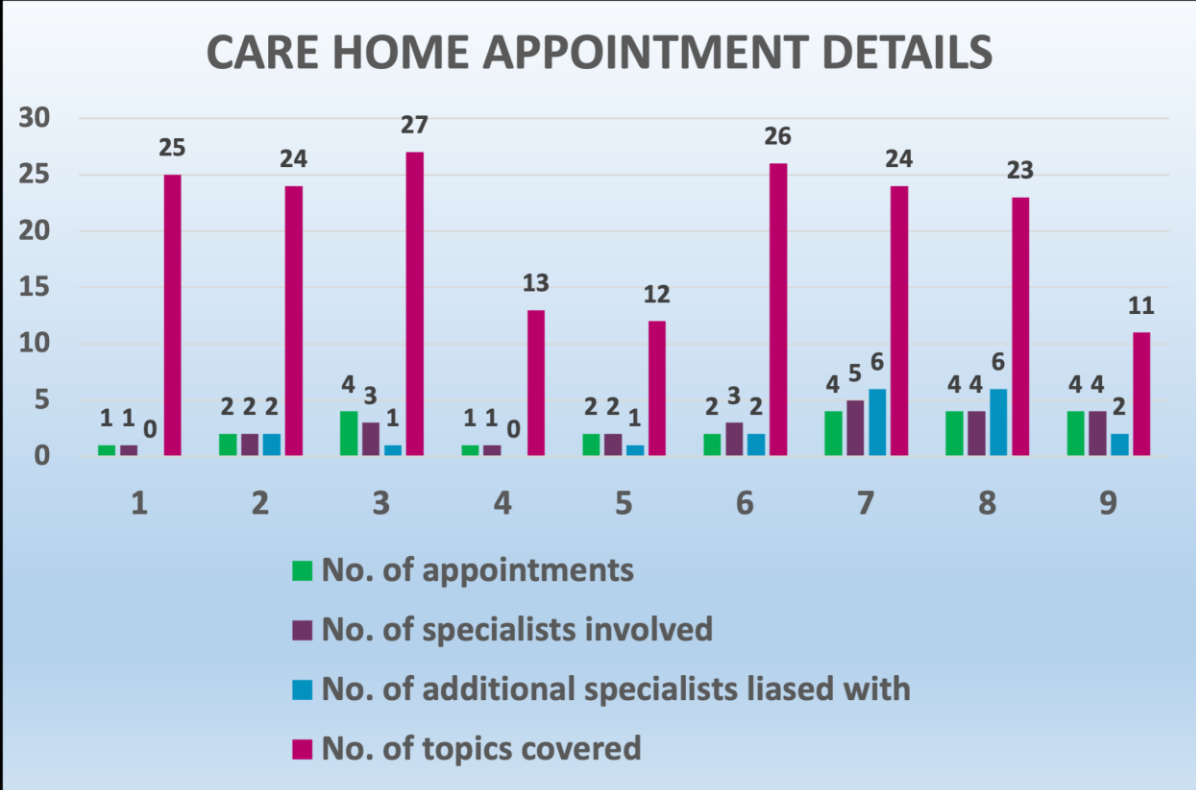


SUMMARY OF RESULTS



- Referral sources varied- most from occupational therapy
- Care home locality locations varied- most from the South-East
- Supporting practitioners varied- most from occupational therapy
- In many cases additional specialist opinions were sought from a range of practitioners
- 13 individual residents were supported, with an average **61% reduction in falls**
- Topics discussed were extensive- with the top 3 being :
 1. mental health, behaviour and well-being
 2. medication and pain control
 3. falls circumstances and falls-related injuries

RESULTS

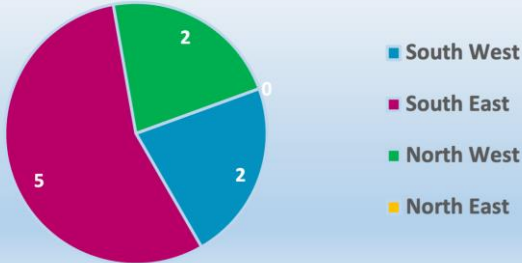


RESULTS

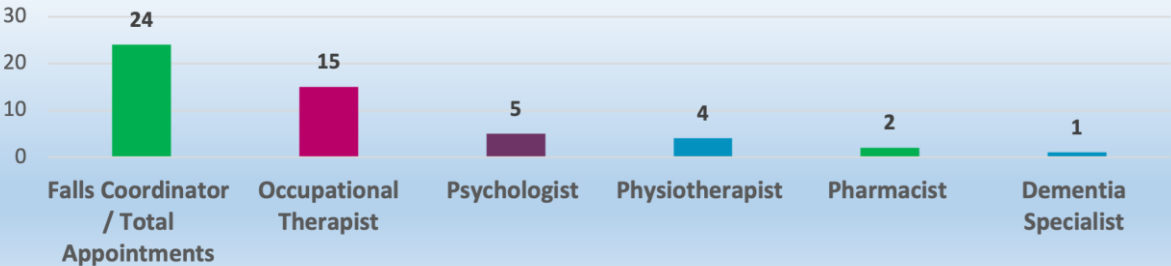
SOURCE OF REFERRAL



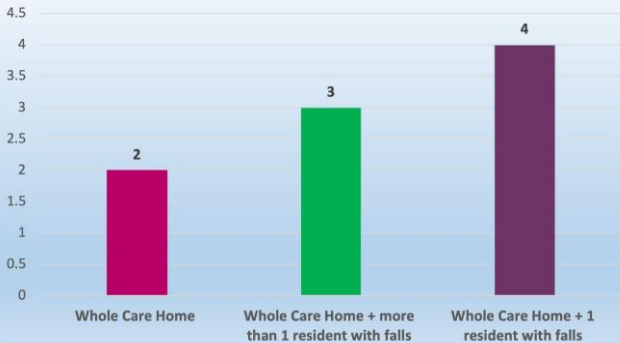
SPREAD OF CARE HOMES PER LOCALITY



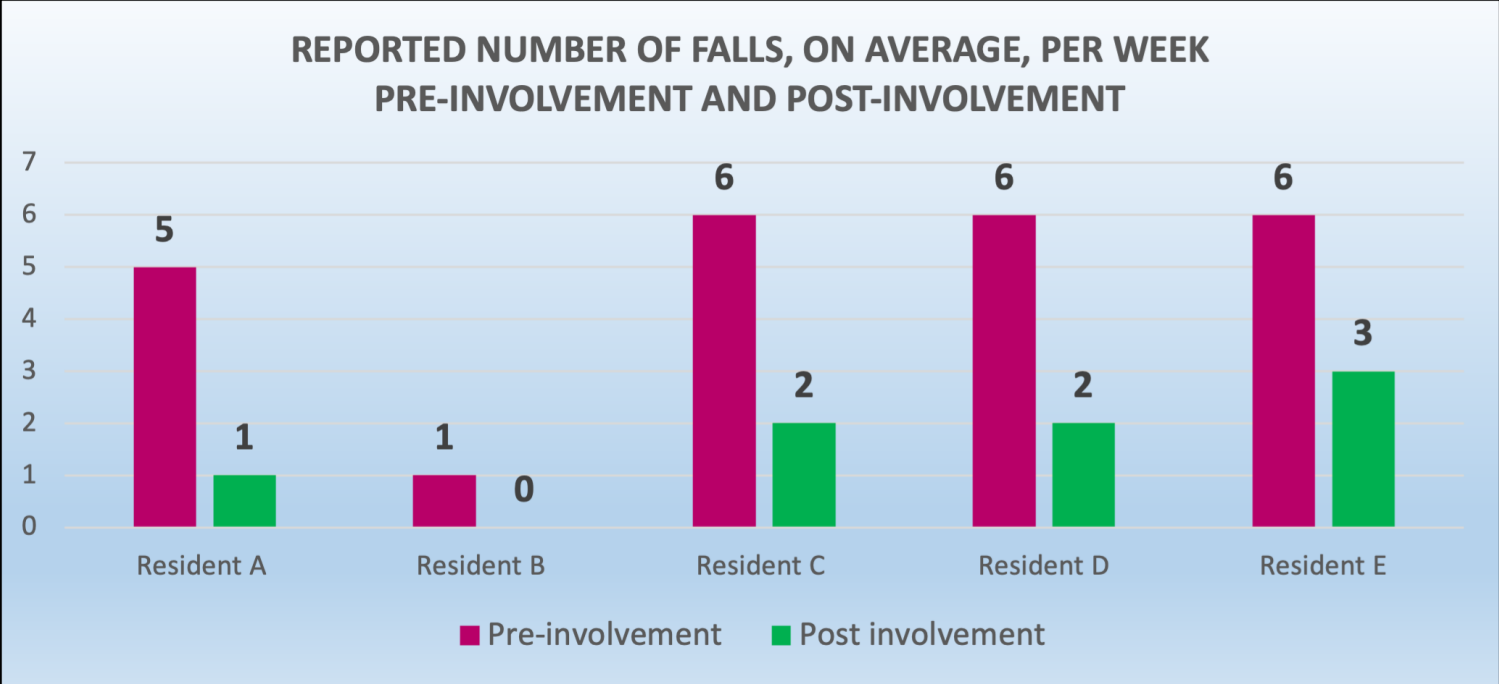
MULTI-DISCIPLINARY SPECIALISTS INVOLVED IN APPOINTMENTS



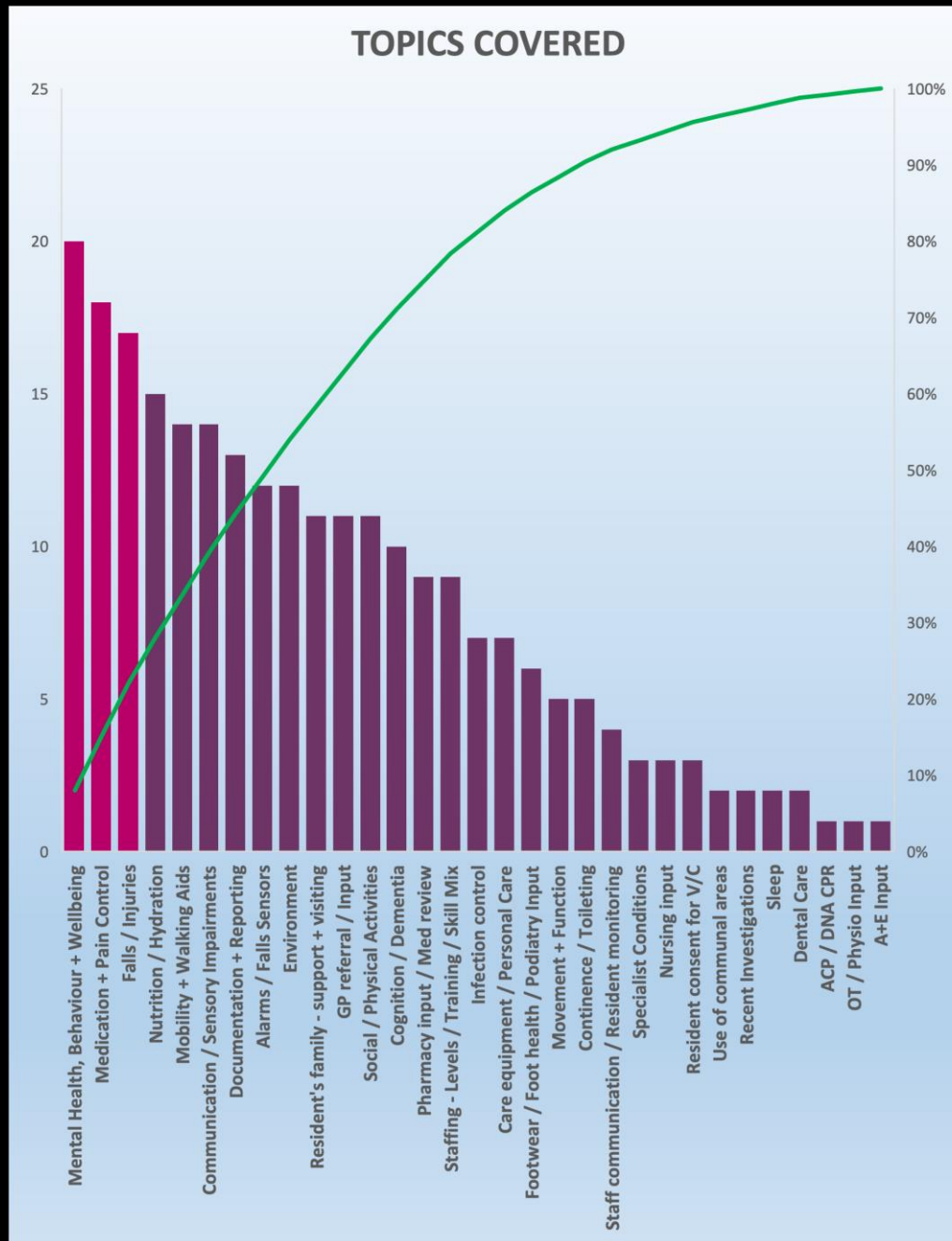
INPUT TO CARE HOME



RESULTS



RESULTS



CASE EXAMPLE 1



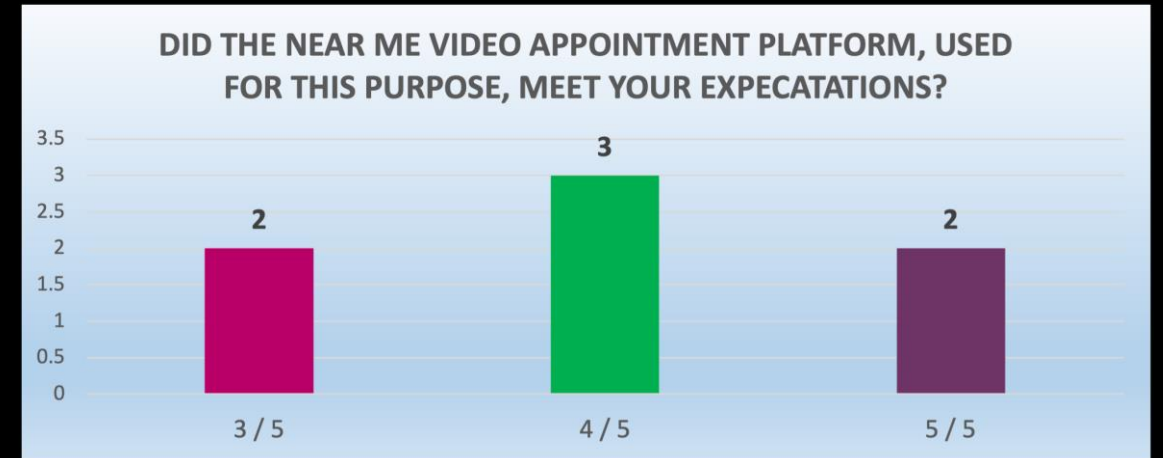
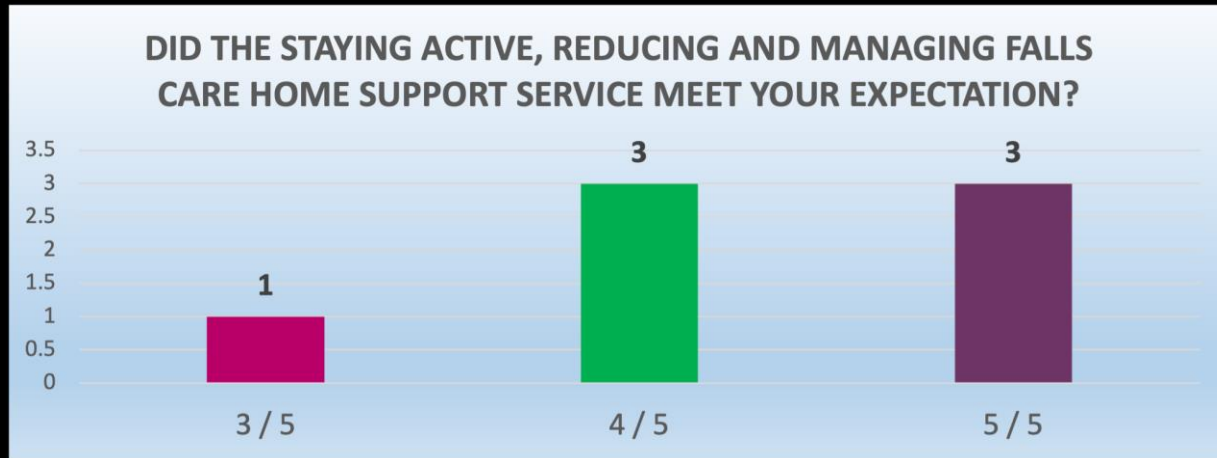
- Physio @ Home referral, individual resident with 5 falls/week, request for consideration for helmet
- Use of helmets for falls researched ahead of 1st appointment
- 1st call manager, nurse lead, falls coordinator, occupational therapist, 2x physiotherapists
 - **Decision that helmet not appropriate and to contact EBSS and dietetics**
- 2nd call preceded by prescribing dieticians contacting care home to discuss needs of individual
 - **Communal activities and falls alarms discussed**
- By 3rd call individual was spending time in communal areas and had gained weight
 - **Psychologist joined call and it was decided that EBSS support was not required**
- 4th call summarized positive outcome and learning, with benefit of individual being around staff and other residents, and falls being reduced to 1 per week
 - **Physical activity options for residents across the care home also discussed**

CASE EXAMPLE 2

- Occupational therapist referral of individual with 5-6 falls per week
- 1st call manager, falls coordinator, psychologist, occupational therapist
 - GP, pharmacy and potentially EBSS input discussed
- Prior to 2nd call the resident fell, requiring A&E input
 - A&E consultant discontinued 7 medications, falls coordinator liaised with GP by email
 - During call deputy CH manager reported improved cognition, communication, nutrition, mobility and significantly less falls
 - Led to discussion about need for unit and potentially care home wide medication reviews
- 3rd call involved two pharmacists
 - Individual showing sustained improvement and a process for unit-wide medication reviews discussed
- 4th call confirmed a reduction to 1-2 falls per week, the introduction of pharmacist-led medication reviews, discussion around falls management and reporting, acknowledgement of staff efforts to provide physical activity options within pandemic restrictions, with a significant weekly reduction in care home wide falls



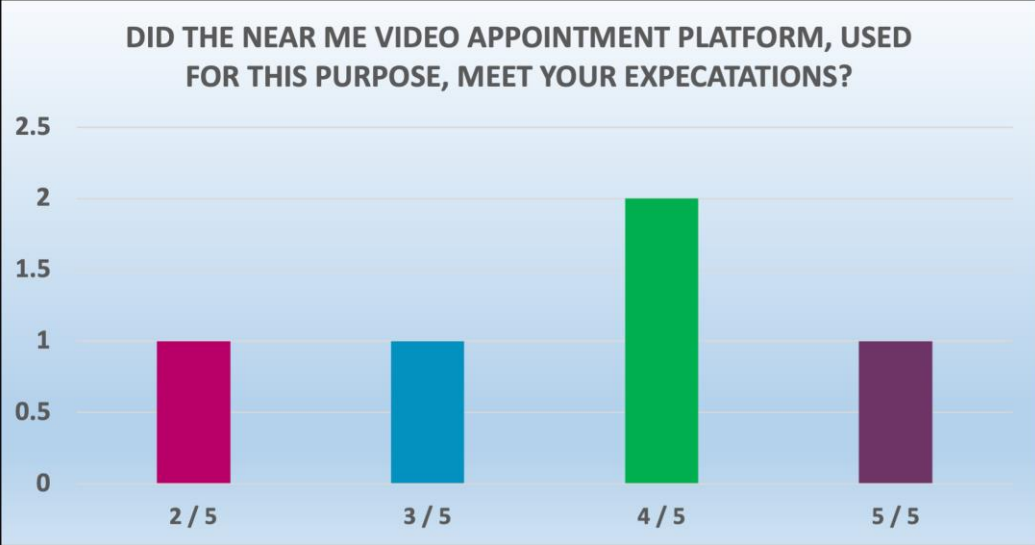
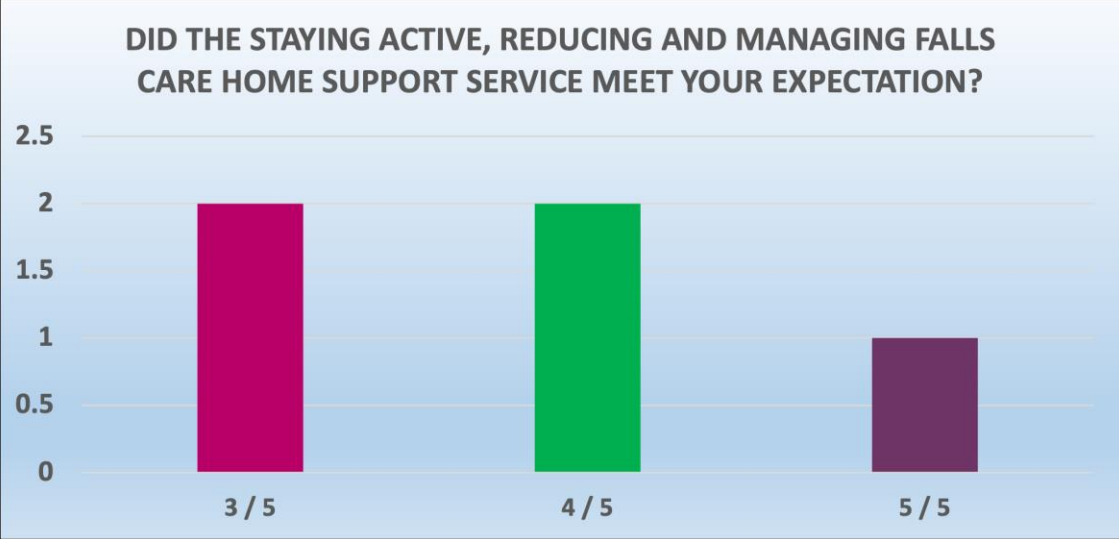
CARE HOME RESPONSES



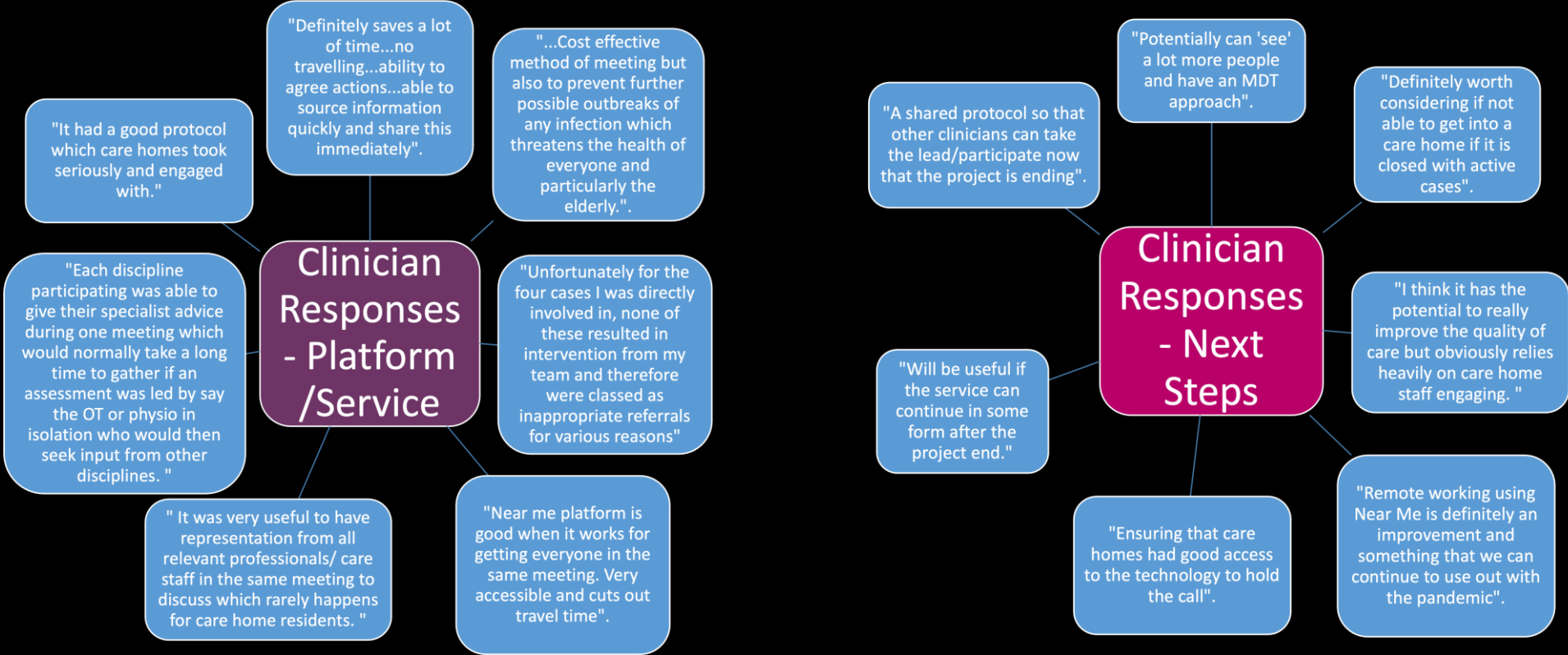
CARE HOME COMMENTS



PRACTITIONER RESPONSES



PRACTITIONER COMMENTS



KEY CHALLENGES AND LESSONS LEARNED



- A service that was adaptive and responsive to the needs of care homes, acknowledging the challenges they faced during the pandemic, and asking little of them in return, was beneficial towards achieving good results
- Project support was essential and invaluable, with additional supportive calls and emails in preparation for meetings, and data collection and processing involved in tasks
- Among the main challenges were IT connectivity, technology availability and confidence in using a new communication platform within a care home with only 4 'screens' incorporated
- The potential to bring residents into the call, while cleared with information governance, was only once utilised
- Record keeping was considered as different services involved on different systems (care plans, AIS, TRAK, GP systems)- it was agreed that all those involved in calls kept their own records
- While all involved were aware falls are multifactorial, some care home input involved the discussion of up to 27 topics, underlying just how diverse the challenge of reducing falls and promoting physical activity is in this setting

DOCUMENT DEVELOPED

First contact practitioner checklist



Edinburgh Health and Social Care Partnership

Falls and Physical Activity in Care Homes First Contact Practitioner Checklist



Care home: _____ Clinician/CH Staff Member: _____
 Date: _____ Meeting number: _____

Please choose one (if needed add a new sheet for additional residents or whole care home):
 Individual Resident Name: _____ DOB: _____
 Whole Care home/unit

Background information:
 Recent falls history:

Topics to consider covering*: *with reference to the Managing Falls and Fractures in Care Homes, Good Practice Resource from the Care Inspectorate ** this checklist should not replace the standard record keeping for your profession or organisation	
Resident Consent for Video Consultations: <input type="checkbox"/> Notes:	Falls History: <input type="checkbox"/> Notes:
Specialist Conditions (PMH): <input type="checkbox"/> Notes:	Medication + Pain Control: <input type="checkbox"/> Notes:
A+E Input: <input type="checkbox"/> Notes:	Pharmacy Input/Medication Review: <input type="checkbox"/> Notes:
Mental Health, Behaviour + Wellbeing: <input type="checkbox"/> Notes:	GP Referral/Input: <input type="checkbox"/> Notes:
Recent investigations (blood/urine): <input type="checkbox"/> Notes:	Injuries (inc. imaging/surgery/rehab): <input type="checkbox"/> Notes:
Movement + Function: <input type="checkbox"/> Notes:	Mobility + Walking Aids: <input type="checkbox"/> Notes:
OT / Physio Input: <input type="checkbox"/> Notes:	Anticipatory Care Planning/DNA CPR: <input type="checkbox"/> Notes:
Communication/Sensory Impairments: <input type="checkbox"/> Notes:	Cognition/Dementia: <input type="checkbox"/> Notes:
Staff communication/Resident Monitoring: <input type="checkbox"/> Notes:	Staffing – Levels/Training/Skill Mix: <input type="checkbox"/> Notes:
Care Equipment/Personal Care: <input type="checkbox"/> Notes:	Continence/Tolieting: <input type="checkbox"/> Notes:

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Nutrition + Hydration inc. Weight: <input type="checkbox"/> Notes:	Footwear/Foot Health/Podiatry Input: <input type="checkbox"/> Notes:
Environment (Care home): <input type="checkbox"/> Notes:	Environment (Room): <input type="checkbox"/> Notes:
Use of Communal Areas: <input type="checkbox"/> Notes:	Social Activities/Physical Activity: <input type="checkbox"/> Notes:
Alarms/Falls sensors: <input type="checkbox"/> Notes:	Infection Control: <input type="checkbox"/> Notes:
Sleep: <input type="checkbox"/> Notes:	Resident's Family/NOK – support + visiting: <input type="checkbox"/> Notes:
Nursing input: <input type="checkbox"/> Notes:	Dental Care/Other Specialist team input: <input type="checkbox"/> Notes:
Documentation & Reporting: <input type="checkbox"/> Notes:	Falls Data Trends: <input type="checkbox"/> Notes:

Summary Plan: (e.g. signposting, referrals, adaptations, specialist opinions etc.)

Signed: _____ Role: _____ Date: _____

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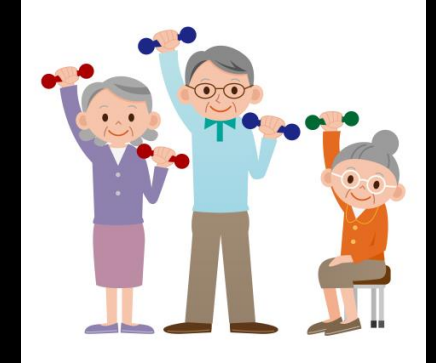


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DISCUSSION

- This project highlighted:
 - The multi-factorial nature of falls in care homes
 - The ability of a coordinated, multi-disciplinary approach facilitated a significant reduction in falls- 61%
 - The approach accelerated access to expertise for staff and individuals in care homes
 - It also saved travel and liaison time for practitioners
 - It showed the necessity and ability for services to care homes to be able to adapt and continue to provide effective coordinated services when a care home is closed for infection control reasons
 - It highlighted the differences in referral criteria and pathways between services supporting care homes
 - It showed the need for specialist support both for individual residents and across whole care homes
 - It showed the potential yet challenges of using technology to support achieving these results



SUMMARY AND NEXT STEPS



- The service delivered within this project was effective in significantly reducing falls
- A coordinated multi-disciplinary approach to supporting care homes in reducing falls and promoting physical activity is required
- All first-contact practitioners asked to review a care home resident with falls should consider a multi-factorial and multi-disciplinary approach as this is likely to have the greatest benefit in reducing falls
- While in-person visits are often optimal, the potential to utilise technology to facilitate multi-disciplinary meetings should be continued and maintained, with challenges around this addressed
- The potential to bring individuals, their families and next of kin into calls or meetings needs considered
- Optimal record keeping for care home residents to allow information sharing between practitioners supporting the same care homes may need considered
- Future local approaches to falls reduction, frailty management and physical activity promotion should consider the learning from this project



**THANK YOU!
ANY QUESTIONS?**

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