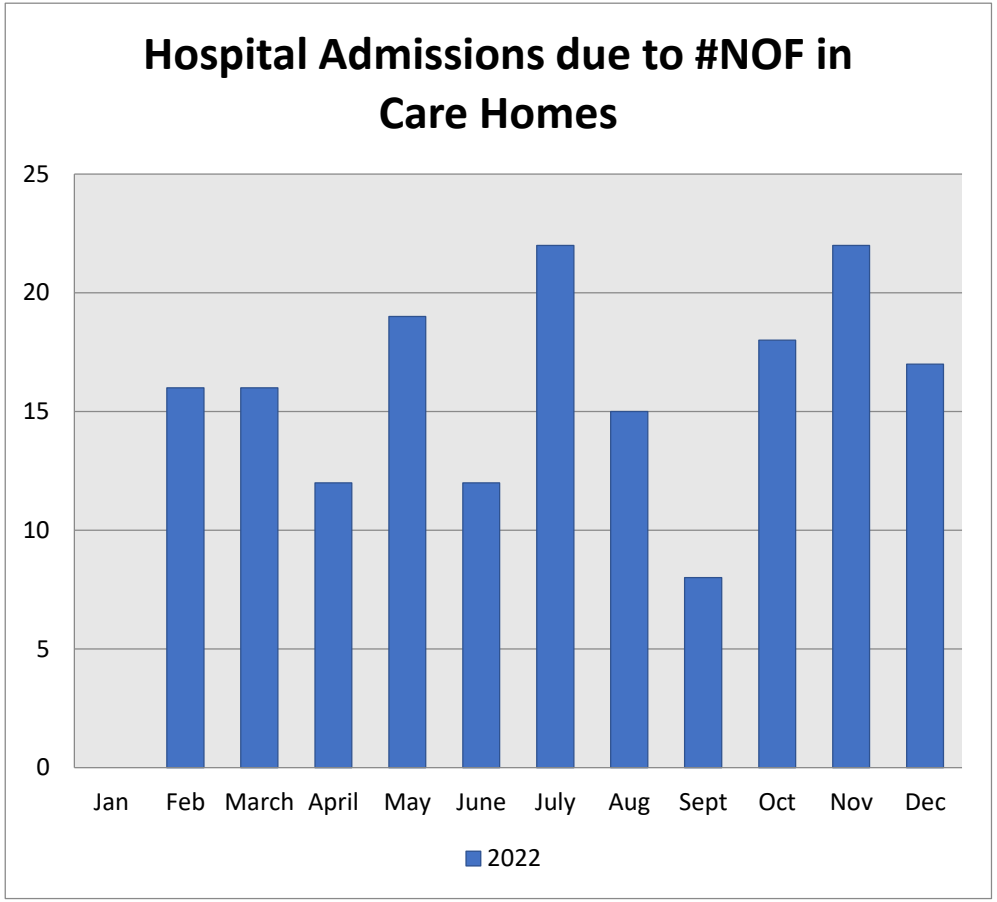
Falls and Frailty Clinical Education in Care Homes in Lothian

Michelle Watt, Care Homes Falls and Frailty Clinical Educator

Background

31,000	• People living in CH in Scotland (2022)[1]
3x	• More likely to fall if you live in a CH[2]
177	• Number of admissions to RIE orthopaedics dept with #NOF in 2022 from CH in Edinburgh



1. Public Health Scotland. Care home census for adults in Scotland [Internet]. 2022 [cited 2024 Feb 07]. Available from: https://publichealthscotland.scot/publications/care-home-census-for-adults-in-scotland/care-home-census-for-adults-in-scotland-statistics-for-2012-2022/
2. Care Inspectorate. Managing falls and fractures in care homes for older people – good practice resource [Internet]. 2016 [cited 2024 Feb 07]. Available from: https://www.careinspectorate.com/images/documents/2712/Falls%20and%20fractures%20new%20resource%20low%20res.pdf

How it all began...

Focus on integrated working with CH sector including delivery of education by NHS clinical education team

Funding secured for 1 year for a falls and frailty CH clinical educator for Edinburgh care homes

Post commenced May 2023

Aims

Aim

By May 2024 Local Authority Care Home staff in Edinburgh City will have increased confidence by 50% when managing a person who has had a fall and will have an overall reduction by 25% of falls resulting in attendance to A+E or acute admission.

Primary Drivers

- Increase confidence managing a resident post fall
- Reduce falls resulting in serious harm
- Reduce presentation to A&E due to a fall

Secondary Drivers

- Education Package
- Staff to be released for training for 2 sessions
- Reporting Tool to be introduced
- Training/Support on reporting Tool
- Falls Pathway to be agreed
- Process for monitoring admissions/presentations to Hospital

Change Ideas

- Offer Falls Reduction Training
- Encourage the use of a Falls Reporting Tool
- Encourage the use of the MFRS
- Update the Care Home website

CH Manager Engagement

On site sessions

1-2 hours long

2 sessions – one ‘refresher’ and one more in-depth

Include bank and agency staffing

Multiple sessions to capture majority of staff

For all grades and specialities of staff

Education Development

2 session model	• Session 1 – Falls and Frailty • Session 2 – Risk assessment, intervention and documentation
Optional Frailty specific module	• Can be added onto session 1

Learning Outcomes

Session 1

- This is an introductory session for all staff on the subject of falls and frailty.
- Learning Outcomes:
- LO1: Describe the reasons people fall including an introduction to frailty
- LO2: Identify falls prevention strategies
- LO3: Use a falls flow chart to explain how to manage a fall
- LO4: Demonstrate what to do post falls regarding who to notify and resident coming home from hospital

Covered pretty much everything. Definetly have more knowledge.

Really enjoyed the training - interactive but fun

Session 2

- This session follows on from Session 1, it is for staff who are involved in completing paperwork related to falls such as risk assessment, handovers and incident reporting.
- Learning Outcomes:
- LO1: Demonstrate an understanding of risk factor assessment and management by using a multifactoral risk assessment tool
- LO2: Demonstrate the use of SBAR-D to handover residents and when completing paperwork
- LO3: Demonstrate the use of falls cross, incident report and falls data spreadsheet

Very good power point presentation and very informative information.

Optional Frailty Session

- An optional comprehensive frailty session which can be added to Session 1
- Learning Outcomes:
- LO1: Describe frailty and frailty syndromes
- LO2: Demonstrate an understanding of the Clinical Frailty Scale and be able to calculate a frailty score
- LO3: Demonstrate an understanding of the goals of frailty care
- LO4: Describe management strategies for frailty and frailty syndromes
- LO5: Discuss the risks associated with frailty and the management strategies for these

EHSCP Falls Documents

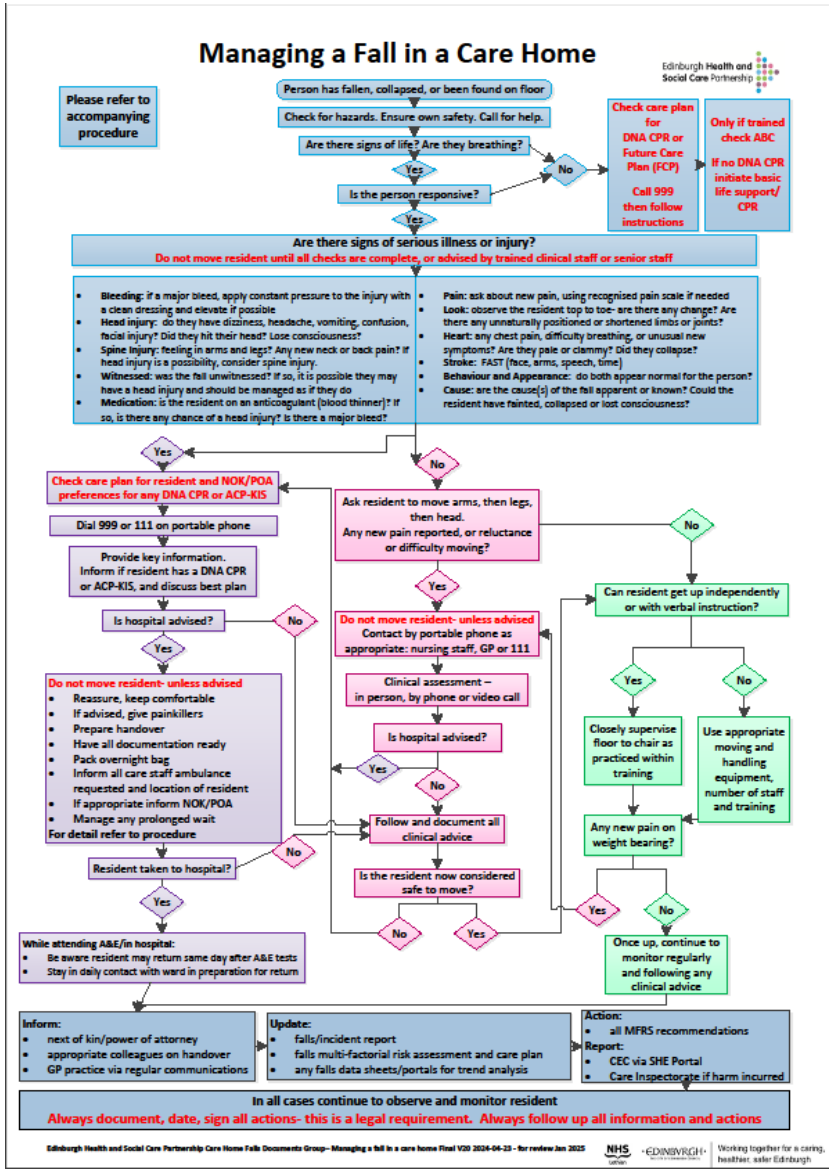
Care Home Multifactorial Falls Risk Screen (MFRS)

Individual name:	Care home/unit:	Date of birth:

Edinburgh Health and Social Care Partnership

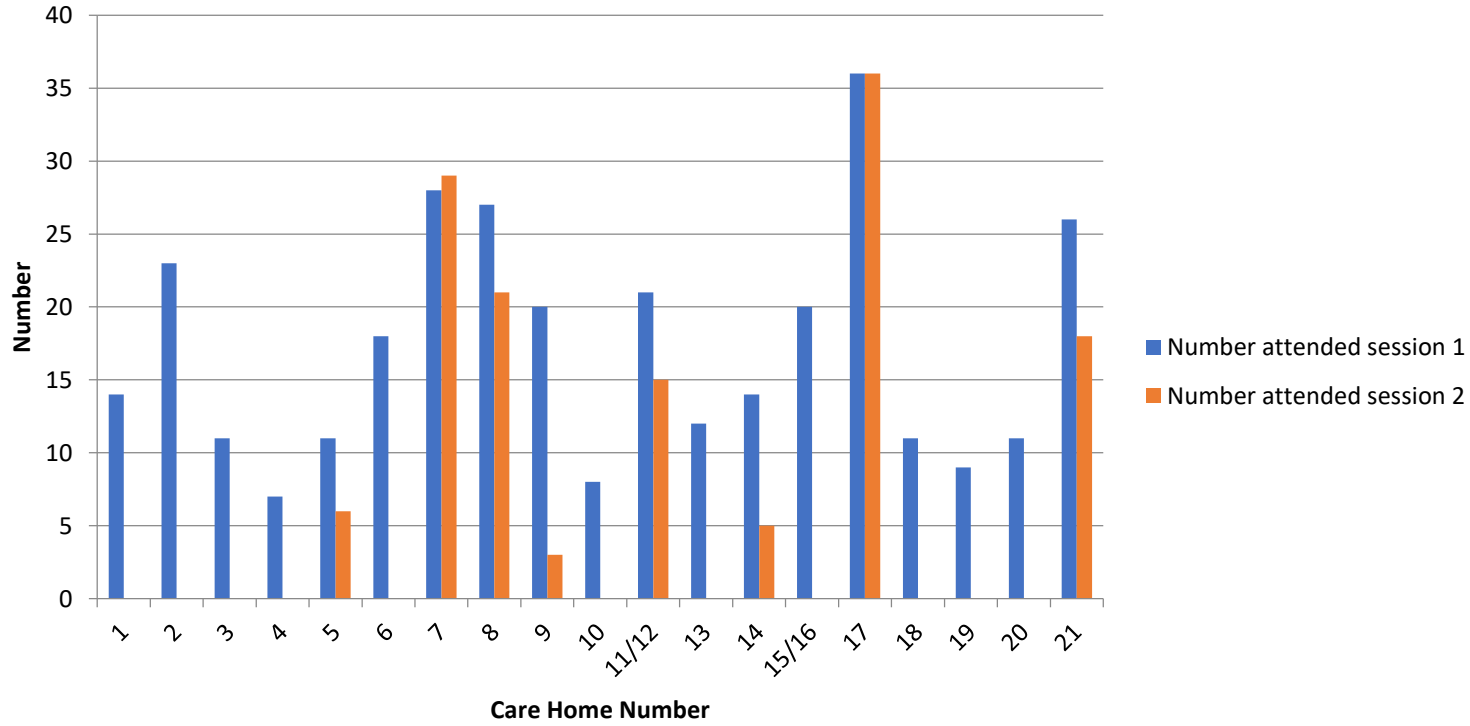
Falls history	Confusion and cognition	Mobility, strength & balance	Medication	Continence	Nutrition and hydration	Health conditions and symptoms	Vision and hearing	Environment	Foot health and footwear	Bone health
Previous falls, their causes, and any intervention	If the individual has cognitive impairment/ learning disability/ dementia, or is more confused?	If the individual has walking aids and is steady and confident?	If individual is taking medication that may increase falls risk, any side effects, and if pain is well managed?	Are they continent of urine/ faeces or are toileting habits normal?	Do they have a normal weight, good fluid/ nutritional intake?	Existing health conditions or symptoms that may relate to balance.	Do they have normal or impaired hearing or sight?	Environment safe and suitable for the individual	Are their feet healthy and is their footwear suitable?	Does individual have diagnosis of osteoporosis or risk factors?
Consider:	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**	**Consider:**
• Previous falls: – Number – Date(s) – Frequency – Location – Time of day – Activity at the time – Contributory factors • Any patterns • Pre-admission falls prevention strategies. • If the individual is worried about falls	– Pain – Dehydration Constipation – Mood/ emotion – Infection – Delirium – Medication effects – Terminal agitation • Use of telecare-buzzers/sensors • Calm environment • Bed safety • Consider night patterns. • Meaningful activity • Refer to GP or mental health team	• Does the resident have Clinical Frailty Scale (CFS) score? • Professionally fitted walking aid, functional in good condition? • Manualhandling assessment • Support to build confidence. • Encourage appropriate physical activity. • Evidence-based strength balance programmes • Refer to OT or physio.	• Medication acting on heart, circulation, or brain. • Lying/standing blood pressure and heart rate • Any side effects. • Compliance • Recognised pain assessment tool. • Pain well managed • Medication review within the last year • Refer to GP, pharmacist, or mental health team for review.	• Consider infection. • Continence bundle • Distance to toilet, toileting regime, clothing, use of telehealth-nightlights buzzers/ sensors • Equipment- e.g. – Commode – Urinal • Catheter bag secured to leg. • See nutrition, hydration, and medication advice. • Referral to continence service and/or OT	• Use MUST tool. • Use fluid chart. • Consider prescribed diet. • Encourage good. fluid intake, avoiding excessive caffeine / alcohol and good oral hygiene • Refer to speech and language therapy (swallowing/ mealtime difficulties), dietician (nutrition), and dentist (mouth) guidance	• Lying/standing blood pressure and heart rate • Symptoms e.g. – Dizziness – Blackouts – Chest pain – Palpitations – Headaches – Fainting – Visual changes • Conditions e.g. – Diabetes – Parkinson's – Stroke • Medication and condition management • GP or specialist team referral	• Ensure aids in place and in good condition. • Annual vision/ and hearing test • Ensure suitable lighting and environment. • Check for ear wax. • Dementia and sight-loss-friendly environment • Consider night patterns. • Refer to optician or audiology	• Orientation of resident to environment • Environment assessment tool • Consider aids, appliances and/or signage. • Consider manual handling. • Use of telecare-buzzers/sensors • Consider night patterns. • Buzzer/aids in easy reach • Referral to OT	• Regular suitable foot assessment and care regime supported by staff. • Liaise with resident and family regarding suitable footwear- see podiatry guidance. • Check for colour, sensation, skin integrity. • Use of and compliance with splints, orthotics, or prosthetics • Referral to podiatry guidance	• Sufficient calcium in diet • Calcium and vitamin D supplementation • Lifestyle advice for example sunlight exposure • Alcohol reduction and smoking cessation advice • Weight-bearing activity • Discuss with GP bone health management and medication.

Adapted from the Care Inspectorate Good Practice Resource 'Managing Falls and Fractures in Care Homes for Older People' V18 2024-04-23 FINAL



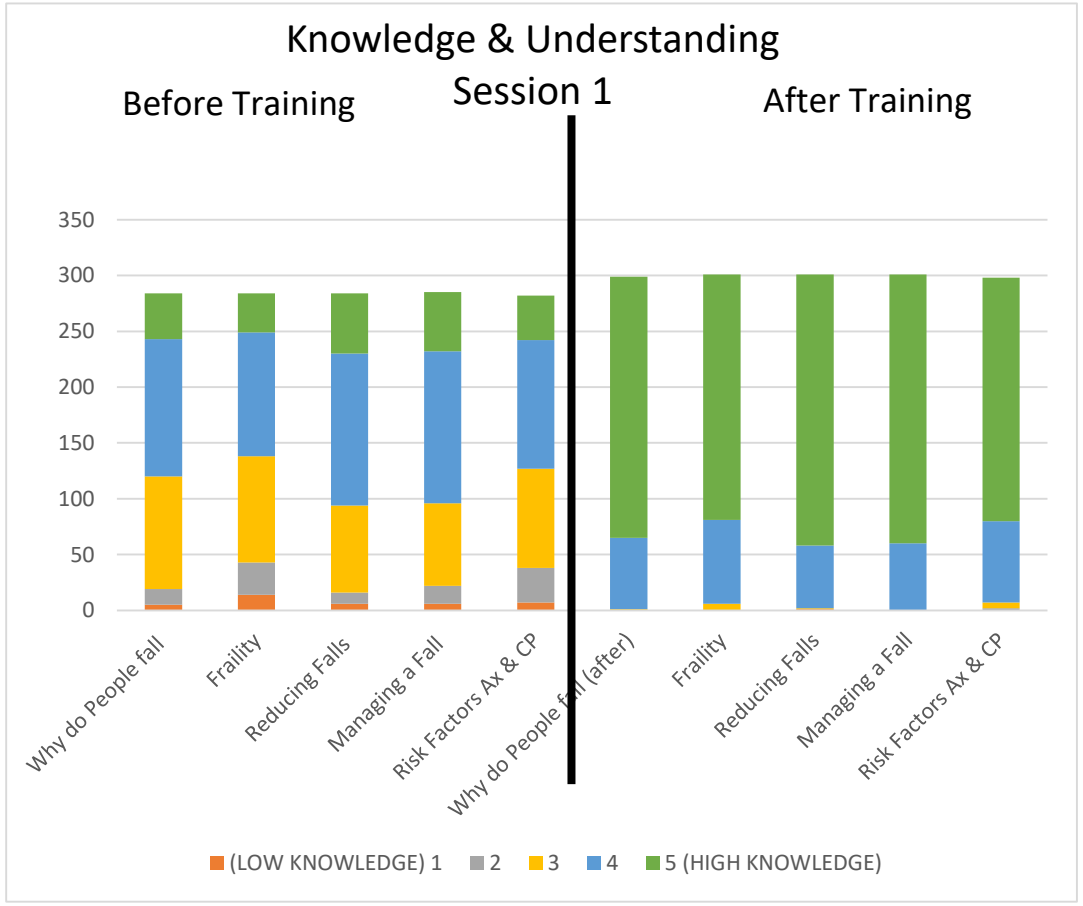
Results

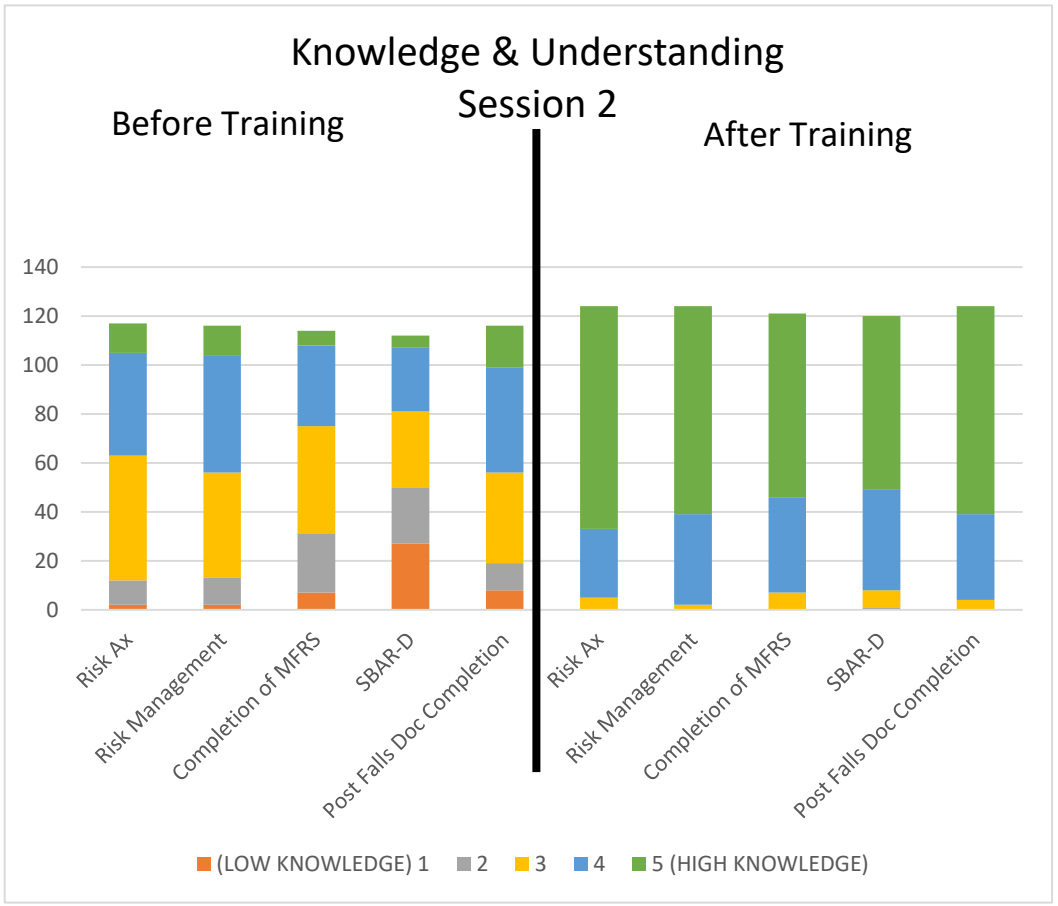
- **Number of CH who have received session 1 or 2 (Until 30/04/2024)**
  - 21 (15 EHSCP, 2 ELHSCP, 3 MLHSCP, 1 WLHSCP)
- **Total number of attendees**
  - 460
- **Attended session 1**
  - 327
- **Attended session 2**
  - 133



Results

Confidence ratings





Results

Confidence ratings

	Why do People fall	Why do People fall (after)	Change	Frailty	Frailty (after)	Change	Reducing Falls	Reducing Falls (after)	Change	Managing a Fall	Managing a Fall (after)	Change	Risk Factors Ax & CP	Risk Factors Ax & CP (after)	Change
(LOW KNOWLEDGE) 1	2%	**0%**	-2%	5%	**0%**	-5%	2%	**0%**	-2%	2%	**0%**	-2%	2%	**0%**	-2%
2	5%	**0%**	-5%	10%	**0%**	-10%	4%	**0%**	-4%	6%	**0%**	-6%	11%	**1%**	-10%
3	36%	**0%**	-35%	33%	**2%**	-31%	27%	**0%**	-27%	26%	**0%**	-26%	32%	**2%**	-30%
4	43%	**21%**	-22%	39%	**25%**	-14%	48%	**19%**	-29%	48%	**20%**	-28%	41%	**24%**	-16%
5 (HIGH KNOWLEDGE)	14%	**78%**	64%	12%	**73%**	61%	19%	**81%**	62%	19%	**80%**	61%	14%	**73%**	59%

	Risk Ax	Risk Ax (after)	Change	Risk Management	Risk Management (after)	Change	Completion of MFRS	Completion of MFRS (after)	Change	SBAR-D	SBAR (after)	Change	Post Falls Doc Completion	Post Falls Doc Completion (after)	Change
(LOW KNOWLEDGE) 1	2%	**0%**	-2%	2%	**0%**	-2%	6%	**0%**	-6%	24%	**0%**	-24%	7%	**0%**	-7%
2	9%	**0%**	-9%	9%	**0%**	-9%	21%	**0%**	-21%	21%	**1%**	-20%	9%	**0%**	-9%
3	44%	**4%**	-40%	37%	**2%**	-35%	39%	**6%**	-33%	28%	**6%**	-22%	32%	**3%**	-29%
4	36%	**23%**	-13%	41%	**30%**	-12%	29%	**32%**	3%	23%	**34%**	11%	37%	**28%**	-9%
5 (HIGH KNOWLEDGE)	10%	**73%**	63%	10%	**69%**	58%	5%	**62%**	57%	4%	**59%**	55%	15%	**69%**	54%

What could have been better?

- More consistent engagement from CH – more proactive, less reactive

- Already having the EHSCP falls procedure and documentation ready to go for the start of the project

Future plans

- Funding was secured for a further 6 months which will enable the roll out of the education package to the rest of Lothian. Sessions have already been booked for East, Mid and West Lothian while continuing with the roll out in Edinburgh.
- The potential for an in-person falls and frailty simulation day is being explored.
- Looking for other homes to trial the Edinburgh Local Authority falls documentation as part of QI projects.

Any Questions?