ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

NASMeD
National Ambulance Service Medical Directors

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Falls Response Governance Framework for NHS Ambulance Trusts

PURPOSE

This document has been developed with input from NHS ambulance trusts and members of the National Falls Prevention Coordination Group (NFPCG), which is chaired by Public Health England (PHE).

It has been produced as a key output from the NHS England and NHS Improvement Safely Reducing Avoidable Conveyance programme as an initial step in supporting access to appropriate care for people who have fallen.

The purpose of this document is to outline a national ambulance service approach in response to people who have fallen to ensure that they receive appropriate care, treatment and access to falls prevention services, and when safe to do so, avoid conveyance to hospital emergency departments (EDs).

It describes the underpinning principles and clinical governance for providing responsive, compassionate and person-centred services for people who have fallen or who are at risk of falling.

The framework intends to:

- Articulate how ambulance trusts and partners in the health, social care and the voluntary sector respond to people who have fallen
- Provide clarity on roles and responsibilities of ambulance trusts in relation to falls and falls prevention
- Describe how ambulance trusts can have the greatest impact on falls and fractures
- Support collaboration and interoperability between health systems
- Meet the needs of people who have fallen using a system wide approach to falls and falls prevention
- Recognise that a system-wide approach to falls is needed.

Additionally this framework can be used by commissioning bodies in optimising services for falls and fractures, falls prevention and responses to falls in community settings, including care homes. Local context will need to be considered alongside this framework in terms of integration of relevant services, however, the principles are applicable across the UK.

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Definition of a fall

'A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.'[1]

Scope

This document is provided as a framework for NHS ambulance trusts. It is recognised that ambulance services are often contacted in the first instance, either through 999 or 111, for many people who have had a fall or who are at risk of falling, however, many other organisations and providers within the urgent and emergency care (UEC) system are also intrinsically linked to and involved in the management, prevention and response to falls.

The framework recognises that for an Integrated Care System (ICS) to provide comprehensive and seamless services for people who may fall, or have fallen, further work needs to be undertaken and connections made nationally and locally between the following organisations*:

- NHS partner providers – ambulance, primary, secondary and community
- NHSE independent care home group
- NHSE Ageing Well programme group
- Telecare Services Association (TSA - the voice of Technology Enabled Care) and partners providing telecare and telehealth solutions
- Public Health England (PHE)
- National Falls Prevention Coordination Group (NFPCG)
- Third Sector organisations e.g. Age UK
- Local authorities
- Domiciliary care providers
- Royal Society for the Prevention of Accidents (RSPOA)
- Fire & Rescue Services (FRS)

** this list is not exhaustive*

This framework also identifies areas requiring further consideration, research and consolidation to ensure patient safety, especially in relation to responding to a person on the floor after a fall.

Principles in safe management of falls

The principles on which this document are based cover five domains which are briefly described below and in further detail in subsequent sections:

1) Prevention

By Making Every Contact Count (MECC) we recognise the opportunities for contributing to the prevention of falls through raising awareness of falls hazards or providing health promotion messages to minimise the risk of a fall. In their everyday interactions with patients, clinicians within primary care, community care and ambulance services can assist in the identification of those who might benefit from falls prevention services and/or signposting to frailty services and /or fracture liaison services.

2) Supporting community resilience

By partners working together across health and social care and the voluntary sector we can support community providers to offer an appropriate and timely response for people who have fallen in the community where an ambulance is not required but where further assessment is needed.

3) Assessment (hear and treat/refer)

By providing an effective and consistent approach to telephone triage as well as face to face contexts, patients will receive the best possible personalised and evidence-based care to meet their needs. This will in turn result in the deployment of an appropriate response/provider to meet those identified needs.

4) Falls response

Not all calls to 999 or 111 in respect of patients who have fallen require a full clinical paramedic response and not all responses require conveyance to a hospital ED. An effective and timely response co-ordinated by the ambulance control or Clinical Assessment Service (CAS) will ensure that the most appropriate, clinically safe response is provided to people who have fallen when they require an urgent or emergency response.

5) Avoiding further harm

Providers can ensure effective pathways are implemented in order that our populations served can receive timely assessment and management of the risk of further falls as well as medical or social assessment and care planning of wider needs to help maintain independence and reduce the risk of further harm.

This framework recommends that providers and other organisations within ICSs involved in falls should work together across these domains in a joined-up manner to provide the most appropriate care and the best experience for those who have fallen or are at risk of falling.

[1] *https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-1-Identifying-people-at-risk-of-falling*

Context

Falls represent a major public health challenge with implications for health as well as urgent and continuing care services.

We need to consider falls in the context of our ageing population and as one of a number of syndromes associated with frailty. 30% of home dwelling people, aged 65 years or older, fall every year[2]. National data show that 50% of people aged over 80 years fall annually. A fall can mark the start of functional decline in over a third of people presenting with a fall. The cost of falling is significant in terms of distress, pain, injury, hospitalisation and loss of independence.

Within adult major trauma patients in England, mechanism of injury is dominated by low level falls, particularly in older people. Falls from a standing height are the commonest cause of major injury in older people. The types of major injury associated with falls in older people include traumatic brain and spinal cord injury, as well as the more commonly referenced hip fractures (95% hip fractures are caused by falls, 40% end up in institutional care, 20% never walk again and 30% die within a year). Current prehospital triage systems are not reliable at identifying older major trauma patients. This may lead to diagnostic and treatment delays for the older, vulnerable patient group.[3]

Falls are a common reason for calling an ambulance - around 8-10% of all 999 calls to ambulance services concern people who have fallen and falls are the most frequent single diagnosis in the over 65 cohort.[4]

There are clearly opportunities to improve health outcomes following falls, prevent further falls and avoid unnecessary transfers to EDs and subsequent admission to hospital. However, the ability to provide a timely response is often challenging due to the ever-increasing demand and the way that triage systems prioritise 999 and 111 incidents currently.

Interoperability between healthcare providers and the referral routes, methods and criteria vary considerably across the country, and the lack of timely sharing of clinical information can cause barriers to effective care. Community service provision can vary in terms of the conditions they treat, the skill mix of the staff and their level of integration with the wider falls prevention or urgent care system. Robust clinical governance associated with falls is vital to ensure safe, high quality care.

Primary Care Networks (PCNs) may employ social prescribers and link workers who can signpost the public to services and interventions that support prevention of falls, for example, strength and balance exercise programmes, or support with housing adaptations. Likewise, CASs within Integrated Urgent Care (IUC) systems can provide triage and signposting for callers to 111 who may benefit from such services and support.

There is a paucity of evidence regarding the safety and outcomes for patients who are not conveyed to hospital following a fall, and in relation to the risks and harms from a 'long lie', when they have fallen and it has taken several hours for ambulance clinicians to get to them or the initial call for help has been delayed. There is no formal definition of a long lie, but the most common definition in the literature is one hour or more on the floor. This gap in evidence requires further research and quality improvements, as do falls linked to people with dementia.

Being in a hospital setting, combined with inactivity leads to 'deconditioning', particularly for people with dementia and delirium who have fallen, which causes people to lose fitness or muscle tone, especially through lack of exercise. It makes sense therefore to reduce the need for hospital admission whenever possible, through alternative care pathways and prevention programmes.

There is limited information about the costs incurred and efficiency savings that can be achieved from various models of response to people who have fallen. Any new models of ambulance response to falls need to consider the costs and benefits at a system-wide level in order to understand the impact that falls prevention and safe reduction in avoidable conveyance can have on other urgent care, primary care, community and social care services. It is important that new services and response models are integrated with other elements of the system and consider the availability of other services and support within the system.

[2] https://www.nice.org.uk/guidance/cg161
[3] Department of Health (2009); Snooks P et al (2006); Weiss et al (2003); Dixon et al (2019)
[4] O Hara et al (2012)

Framework

1) Prevention

The nature of health and social care services places ambulance staff in direct contact with members of the public, often in their own homes. Ambulance staff, healthcare workers and other professionals are afforded a unique and valuable opportunity to assess both the person themselves and the environment in which they live for factors that may increase a person's risk of falling, providing them with important opportunities for proactive intervention, such as signposting or referring people to relevant services and organisations that can help.

The National Institute for Health and Care Excellence (NICE) recommend that older people coming into contact with professionals and organisations that have health and care as part of their remit should be asked routinely about falls.[5] There are many useful leaflets and online resources that ambulance services can refer and signpost to, for example:

- *'Get up and go' – a guide to staying steady*[6] - a 32-page guide for the public and patients on how to prevent falls, produced by Saga in partnership with the Chartered Society of physiotherapy (CSP) and Public Health England
- *Falls and Fractures Prevention - Applying all our health*[7]

The Royal Society for the Prevention of Accidents (RoSPA) provides advice on how to make the home a safer environment.[8]

The National Falls Prevention Coordination Group (NFPCG), which is facilitated by PHE and comprises over 35 organisations involved in the prevention of falls, care for fall-related injuries and the promotion of healthy ageing, has supported the development of a number of resources to address COVID-19 related falls and fracture issues, which are featured in Appendix 1.

A Cochrane systematic review[9] found that risk assessment followed by appropriate interventions for falls prevention reduced the rate of falls by 24%. Referral to specialist community falls prevention teams need to be robust and equitable across all areas to achieve these reductions.

Data collected from Electronic Patient Care Records (ePCR) and the developing Ambulance Data Set (ADS) may support us to better identify persons at risk of falling, those who are having recurrent falls, and contribute to the detection of frailty.

Ambulance services providing non-emergency/scheduled patient transport services will also have unique opportunities for recognising people at risk of falling, assessing potential falls hazards and referring to appropriate agencies such as community therapy or falls prevention services, local authority housing and services which provide support for home improvements, for example *Care and Repair England and Foundations*, the national body for Home Improvement Agencies in England and can identify hazards as part of multifactorial interventions (www.foundations.uk.com).

Ideally every geographical area will have a commissioned service for falls prevention, with strength and balance exercise programmes, specialist falls and fractures clinic access. Patients at risk of further falls should be taught falls coping strategies including techniques of how to get up safely, such as backward chaining, and what to do if they are unable to get up and who to call for help. Ambulance

[5] *https://www.nice.org.uk/guidance/cg161/chapter/1-recommendations*
[6] *https://www.csp.org.uk/publications/get-go-guide-staying-steady-english-version*
[7] *https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health*
[8] *https://www.rospa.com/home-safety/advice/older-people/#falls*
[9] *https://www.cochrane.org/CD012221/MUSKINJ_interventions-based-individual-assessment-falls-risk-and-multiple-component-interventions-preventing*

services should have referral pathways in place to refer people who are at risk or have fallen to these services.

Ambulance services cover a large geographical footprint therefore there is a need to work with providers towards a single point of referral and a standardised referral process/referral form for patients after a fall. The timeframe of follow up for the patient should be agreed at the point of referral. Referral pathways into frailty services need to be more developed and widespread, along with the availability of 'virtual wards' and 'hospital at home' schemes to ensure hospital admission is avoided if possible. People at risk of a fall may also need to be referred, for example, through the local PCN to a 'social prescriber' so that plans can be developed in case of a future fall.

In addition to onward referral of a patient after a fall, safety netting should include what to do in the event of a further fall or a deterioration in their health, when to seek advice and who to contact. Patient advice leaflets (preferably standardised[10]) can be left with people assessed as being at risk of falls, to provide information around simple strength and balance exercises and where to find more information regarding falls prevention.

2) Supporting community resilience

Within care homes and domiciliary care providers

Ambulance services are often called to attend people who have fallen in care home settings or where a domiciliary carer finds a service user on the floor when attending their home. They are not, however, commissioned to provide a lifting or moving service for residents who are well and not injured in care homes, or where domiciliary care is provided, but they will respond to 999 emergency calls to care providers when a clinical assessment is required.

Care providers have an obligation to conduct their own moving and handling risk assessments on all their residents and service users. There is an expectation that under their duty of care, providers of such services ensure that their staff have sufficient and appropriate moving and handling training.

Associated equipment to enable safe management of those in their care should be readily accessible (although this is obviously harder to achieve and use for domiciliary carers who may be working alone). This is a statutory obligation under the Health and Safety at Work Act (1974).

As well as incorporating falls risk assessment training, care homes and domiciliary care providers should have policies and procedures on how to manage a resident/service user who falls, including how to get the person up from the floor, how to access and use mechanical lifting aids, how to use the persons own equipment to support them from the floor and when to call for additional support/advice, for example, via 111/999.

Procedures could be in the form of a flowchart or check list and various models exist in some care homes where often their local ambulance service has provided advice on these. These policies and processes should be consistent, and not automatically default to calling 999 for a person on the floor.

It is unacceptable for care providers to routinely make requests for an emergency ambulance response to lift uninjured residents (for example, from the floor and return them to bed or sitting) and blanket "no-lifting" polices and protocols should not be adopted in respect of moving and handling operations.

Workforce and recruitment issues coupled with a high turnover of staff in the care sector has led to wide variations in the response they provide and the ability to safely manage people who fall.

[10] *www.profound.eu.com (use a standard leaflet - but these may need to be adapted to include local information)*

Case study example: Falls response training for care homes

Some ambulance services, like the North East Ambulance Service NHS Trust (NEAS), have been involved in delivering training sessions in care homes enabling them to better support older people who have fallen in a care home environment. The intended outcomes of this work are to ensure that patients receive a timely and appropriate response to their needs, which does not always include an ambulance response.

NEAS worked with their North of England Commissioning Support team and at least seven local Clinical Commissioning Groups (CCGs) and local authorities to develop and supply Falls Initial Response Skills Training (FIRST) to residential care homes in the North East and North Cumbria.

They deliver an accredited, standardised approach across the region to falls prevention training and education in knowledge and skills needed for when a resident has a fall. This results in better care provision for residents and their families, reduces the number of residents who require hospitalisation following a fall and proactively prevents them from experiencing falls. In the first year of providing this training (2016/17) to 115 care homes (414 delegates) calls to 999 from these homes reduced by 32% over a comparative period before and after training.

The course is a one-day training programme of six hours, which can be flexibly delivered as and when, or where, needed. Further discussion is underway to introduce a train-the-trainer course to ensure sustainability of skillsets and respond to staff turnover within the care homes.

Case study example: National Care Home Project- Collaboration between Welsh Government, Emergency Ambulance Service Commissioner and Welsh Ambulance Service NHS Trust (WAST)

In 2018 WAST in collaboration with Welsh Government and The Emergency Ambulance Service Commissioner (EASC) identified a total of 604 care homes who qualified for the issuing of lifting equipment and training. Nationally, equipment was delivered to the care homes and was completed by March 2019. A two hour training session was provided to care home staff which included the importance of good decision making after a fall, the use of the ISTUMBLE tool and the use of the Camel Mangar lifting cushion. By June 2019 a total of 358 homes had completed training (61%). The care homes reported immediate results post training; (circa 6-8 weeks). Evaluation directly from the care homes resulted in:

- **125 falls recorded by evaluation group -87% managed the fall in-house in the first instance by using ISTUMBLE to assess the fallen resident**
- **Of the 125 falls, the ambulance was called on 35 occasions (28%)**
- **The Camel was used to lift 56% of the falls.**
- **54 care homes (68%) of care homes have changed their lifting policy from 'No Lift' to Lift with ISTUMBLE and appropriate lifting equipment.**

[10] *www.profound.eu.com (use a standard leaflet - but these may need to be adapted to include local information)*

Volunteer response

Community First Responders (CFRs) provide an essential and valuable contribution in supporting community resilience and responding to other emergency calls including cardiac arrests.

CFR teams in many ambulance trusts are also now responding to people who have fallen (and other types of calls such as calls for welfare check), supporting ambulance resources and often providing a quicker response to a patient when demand is high. Where deemed clinically appropriate, patients are subsequently supported and lifted following a fall. This is always in conjunction with processes to enable remote clinician support and advice via recorded and auditable phone lines and flow processes to reduce risk and harm.

There should be recognition that CFRs and other volunteers provide non-clinical support and are not registered health care professionals. Evidence from current models of using CFRs shows that there is often still a need for a clinical face to face response to back up a CFR. In some areas the use of videoconferencing to support remote clinical triage is proving effective.

Other models for responding to people who fall exist and are in development; examples are:

- Telecare responders
- Community health care teams
- Physiotherapist and Occupational Therapist (OT) models - often working in conjunction with a paramedic response
- St John Ambulance.

It is important that evaluation of any of the above models is built into the planning for falls services. Evaluation should consider re-contact rates and any adverse incidents that arise in relation to piloting or newly introduced models.

3) Assessment (hear and treat)

The initial assessment on receipt of a 999 or 111 call is a critical point in the pathway of care for people experiencing a fall. A rapid and appropriate response, which provides both effective management of the immediate situation and consideration of further health and care needs, is key to preventing unnecessary admission to hospital, functional decline and further falls.

In the UK, and internationally, about 34-40% of older people who fall, presenting to the ambulance service, are not transported to hospital[11] and older people who fall without apparent injury are often assigned a low priority response[12].

999 calls are answered by non-clinicians within a standard system. To ensure that the appropriate response is sent according to the clinical need of the patient, additional remote clinical telephone assessment of the patient is often needed to gather more information, conduct additional triage, understand the reason for the fall and explore if injuries may have been sustained in order to determine the most appropriate response. This needs to be robust, effective and undertaken in the ambulance control or Clinical Assessment Service (CAS). The time that the patient was known to be on the floor should be recorded where possible, whether the call was made to 111 or 999 or via a telecare provider.

Early involvement of a clinician within the ambulance control room, or within the CAS, for 999 or 111 calls related to a patient who has fallen, should be considered and processes developed to support this. Queuing/stacking falls calls whilst waiting for a demand management plan to be instigated may not be appropriate. Additionally, this early clinical assessment should consider providing specific advice such as moving in order to prevent pressure ulcers and muscle damage (if able), taking normal medications, analgesia advice and having a drink (if safe to do so).

Coaching techniques and backward chaining[13] to assist self-mobilisation should be considered early in the call, which may enable the patient to get up from the floor and they may not then need a face-to-face response. The current triage systems in ambulance control rooms should consider these issues and how they can become part of the normal assessment process.

Patients may be at risk if they remain in the normal prioritisation process as a lower category and the wait for an ambulance response is prolonged. The length of time on the floor may be unknown, the patient's condition can become worse due to the position they are laid in and/or the surface they are laid on. The patient's comorbidities and level of frailty may also contribute to that risk. Other factors need to be considered, such as patient age, whether they are alone/vulnerable, level of cognitive impairment/dementia, renal impairment, immunosuppression, incontinence, existing pressure sores and further risk of skin integrity. Risk of traumatic injury should be considered, including head injuries and if taking anticoagulant medication.

Further development and research of using sensitive, specific and standardised remote falls clinical assessment tools within the control room clinical hubs and CAS is needed to facilitate deployment of appropriate resources including upgrading and downgrading the automated responses which may follow standard triage. Triage tools should consider risk factors and the need for early escalation.

Use of video conferencing/tele-medicine should be more widely investigated with regard to its benefit in falls. Where it is introduced between responders and remote clinicians it can aid assessment and decision-making from the time of the call.

[11] *Marks PJ et al (2002)*
[12] *Snooks P et al (2006)*
[13] *https://www.laterlifetraining.co.uk/wp-content/uploads/2015/08/Backward-ChainingS_A4.pdf*

4) Falls response

National public health experts recommend prompt responses to patients who have fallen. Such responses should help the person to get up from the floor, where appropriate, and ensure assessment and onward referral if needed, avoiding hospital attendance and admission if possible[14].

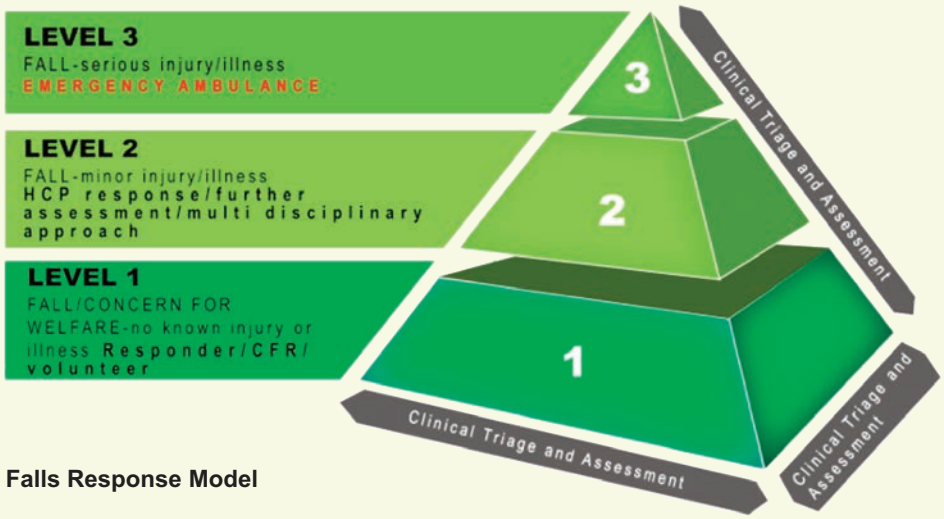
There is an absence of rigorous published evidence or research for the best model of response, however ambulance services have shared their models, governance, risk assessments, data and evaluations to inform this section.

The ambulance Falls Response Model describes three broad levels of response requirement based on patient needs:

1. **Fall - concern for welfare - no known illness or injury**
2. **Fall - minor injury/illness**
3. **Fall - serious injury/illness**

These levels are a guide for clinicians based on the information available from the call to determine the most appropriate type of response for the patient's condition. Where any call is sent for despatch following clinical review/assessment, it must always be done so with one of the agreed ambulance response programme (ARP) categories (Cat 1-4) which could be a higher or lower category than the original call before clinical assessment.

This model recognises that not all falls will require an emergency ambulance response and that many people who have fallen do not need to be conveyed to hospital. However, there is a need for caution in older patients who may have an unrecognised fracture, a head injury or other serious injury from the fall.



Falls Response Model

Ambulance services should consider sending alternative responses to some pre-determined calls based on Advanced Medical Priority Dispatch System (AMPDS) determinant or NHS pathways disposition, for example codes that indicate fall, need assistance and no illness or injury could be sent to alternative response teams.Sending alternative responses should always be overseen by a clinician who can intervene or provide further clinical triage if required. Alternatively, calls can be clinically triaged prior to sending alternative responses, however a pragmatic approach needs to be taken for calls where there is no reply on ring back, contact can't be made directly with the patient or person that is with them or clinician capacity is lacking to ring back within a short time frame. Timeframes should be locally defined to support this.

Level 1:
Fall/concern for welfare
- no known illness or injury

Timeliness of response to these calls is the most important priority to prevent further harm occurring. Lying on the floor for an extended period of time can lead to serious complications including pressure ulcers, rhabdomyolysis, pneumonia, hypothermia, dehydration, and even death.

At times of high demand, and during the COVID-19 pandemic and winter, these calls may 'slip further down the stack' as calls of higher assessed priority come into the service. The long waits that result for older people in this situation has been a theme of many complaints and of concerns identified in some Serious Adverse Incidents.

A Level 1 response is described as an alternative non-clinical responder. The responders may be trained CFRs, volunteers or local telecare monitoring responder teams. The use of fire and rescue service (FRS) personnel may also be considered and locally defined in a Memorandum of Understanding (MOU).

Specific arrangements should be made for provision of response to people who fall who are bariatric to ensure that these patients are not receiving a delayed response and that appropriate equipment for handling and moving is available.

Non-clinical responders should always be trained in areas relating to care of older people and supported by

[14] *National Falls Prevention Coordination Group (2017)*

ambulance service clinicians. They will need to be competent in conducting dynamic risk assessments and be able to contact a clinician for advice, support, clinical decision making, discharge or upgrade of care. Consideration should be given to assessing the fear of falling using instruments such as Short FES-I[15].

Responders for this level can be trained to record clinical observations to include conscious level, heart rate, oxygen saturations, blood pressure, temperature and respiratory rate which will then facilitate the calculation of a NEWS2 score. This would need to include the initial and refresher training for staff, including competency assessments, and the maintenance, servicing and calibration of automated equipment. Further research is needed to determine how essential it is to record a set of clinical observations and how this influences any follow up and onward care.

The responder attends the patient to assist them up from the floor safely or attend a concern for welfare call and undertakes a further assessment. At any point where there is concern for the patient, clinical advice should be sought by the ambulance / CAS clinicians. This may be necessary before moving the patient. The clinician will take overall clinical responsibility for the patient including the discharge of care or ongoing referral and should be accessible for advice and support at all times and possibly by video link.

On any discharge of care following a fall, an onward referral to a community or secondary care multi-disciplinary team, frailty service or falls team for secondary prevention should be made according to local pathways.

Governance considerations for Level 1

To ensure appropriate governance of sending other responders several areas should be documented.

A comprehensive standard operating procedure (SOP) should be developed with partners, along with a signed MOU or referral agreement.

Standard Operating Procedure content	Memorandum of Understanding content
Scope	Risk assessments
Inclusion criteria	Joint commitment
Exclusion criteria	Staff training
Duties and responsibilities	Liability, indemnity and insurance
Information governance	Clinical negligence
Equality and human rights impact statement	Complaints and investigations
Process for audit and review-including cost effectiveness	Safeguarding
Incident reporting	Termination details
Audit arrangements	Review periods
Contact details and review process	Signatories
Training levels of non-clinical and clinical staff	

The alternative responders must have the appropriate equipment and training and be assessed as competent to be able to respond to a person on the floor. This will include:

- Evidence of enhanced DBS check
- Evidence of handling and moving training, e.g. backward chaining techniques along with relevant equipment
- Level one first aid trained as a minimum or CFR training as per national ambulance CFR governance framework
- Safeguarding and vulnerable adult awareness and reporting processes
- Basic assessment of a person who has fallen
- Awareness of how to report incidents
- Ability to conduct a dynamic risk assessment
- Awareness of dementia, frailty, disabilities, sensory disturbances, mental capacity, social and personal care needs
- Appropriate training in base line clinical observations above that of First Aid
- How to document findings
- How onward referrals can be made

[15] *https://sites.manchester.ac.uk/fes-i/*

Level 2:
Fall - minor injury/illness

A Level 2 response is required either when there is an identified or suspected minor injury or illness fall, or it is unclear if there is an injury or illness or where the patient has co-morbidities or complex needs, often associated with emerging frailty. This response may be ambulance service or other appropriate provider.

A Level 2 response is one where a multi-disciplinary team or skilled generalist may be required to undertake a comprehensive assessment of the person in their own home and implement an appropriate care plan according to need. Specialist or Advanced Paramedic Practitioners are able to provide an initial assessment and immediate treatment to support many of these patients to remain at home and signpost /refer for ongoing assessment and support.

Other clinical responders include local community teams consisting of health care professionals (HCPs) including Nurses, Occupational Therapists and Physiotherapists and can respond in conjunction with or without a paramedic. Response models and team availability will vary from area to area. Further local working with partners should be encouraged to ensure a collaborative, integrated care system to support better outcomes for patients.

A full set of clinical observations should be conducted for these patients and recorded with a NEWS2 score calculated.

Responders need to have access to appropriate pathways to refer to health care and social services. Examples may include needing personal carers, night sitters, nursing care, frailty services and social prescribing.

Responders should always have remote access to a senior or specialist professional for support or advice, regarding care, management and discharge. This may be to a range of health professionals and will be determined locally but could be to an ambulance Specialist or Advanced paramedic or nurse, GP, geriatrician, frailty service or allied health professions (OT/physiotherapist). Referral for further falls prevention should also be considered and available locally.

Level 3:
Injury/illness fall

Where initial triage or hear and treat assessment has identified that a person has suffered a serious injury or is unwell following a fall and needs emergency assessment, conveyance to an ED, or conveyance to an alternative destination, an emergency ambulance response should be arranged in accordance with the priority level determined by the national ambulance triage systems (MPDS or NHS pathways).

Emergency Operations Centre (EOC)/111 clinical triage and assessment

An essential component of this Falls Response Model is on-going clinical oversight, clinical triage and assessment within the EOC clinical hub or CAS. At any stage of the model, the patient may be assessed and escalated either up or down the levels, according to need.

Opportunities exist for further integration of the calls for falls that are received into 999 and 111 to identify the appropriate response and services available, regardless of where the call is received. Consideration of a specialist desk for falls, potentially staffed by health care professionals from a range of professions in addition to paramedics.

5) Avoiding further harm

Identification of frailty and utilisation of falls/frailty referral pathways

Falls and frailty are enmeshed. Whilst some falls may have an extrinsic origin, most falls in older people arise from a multiplicity of interacting risk factors e.g. sarcopenia, medication, low blood pressure.

Recurrent falls may be a manifestation of frailty or other underlying conditions. Signposting of these patients to appropriate community-based services is important to prevent and avoid further harm. As non-medical prescribing evolves it is likely that senior clinicians will be able to assist further, using this skill set, to prevent the unintentional consequences of polypharmacy. Referrals for medications review by a pharmacist or GP should be considered. The utilisation of community-based falls and/or frailty referral pathways by clinicians for all patients that are not conveyed to hospital after a fall is appropriate.

Ambulance services need to work with partners from a variety of disciplines and recognise the potential to support falls prevention work within the community e.g. having direct access to the Directory of Services (DoS), to equipment and supplies, as well as the potential to refer directly to falls prevention teams and fracture liaison services.

Prevention of pressure ulcers

Prevention of Pressure Ulcers published by Public Health England (2015) reported 25,000 patients developed a new pressure ulcer in England between April 2014 to the end of March 2015. Immobility as a main risk factor in tissue viability and pressure damage could also be associated with patients who have fallen and are unable to move adequately, and to patients who have had a 'long wait' for an emergency response whilst on the floor. Continuing Professional Development (CPD) programmes for ambulance clinicians should incorporate awareness training pertaining to tissue viability. The significance of pressure ulceration in the context of safeguarding should also be actively considered.

National Falls Response Governance Framework: further potential

Whilst this framework has been developed for ambulance services and therefore has an out-of-hospital setting focus, the principles of the five domains apply across all health and social care settings. Ambulance services need to be engaged and contributing to ICS planning for falls services. Their data and experience can help identify and clarify where local falls services need to be developed in order to maximise opportunities within this framework and response model and thus augment the cumulative and integrated effort for success.

Appendix 1

The National Falls Prevention Coordination Group (NFPCG), which is facilitated by PHE and comprises over 35 organisations involved in the prevention of falls, care for fall-related injuries and the promotion of healthy ageing, has supported the development of a number of resources to address COVID-19 related falls and fracture issues, which are featured below:

Specific falls-related area	Resource	Source
Hospital discharge	A script to support organisations and volunteers involved in the hospital discharge of patients with mobility issues not requiring rehabilitation services; information and resources for patients with mobility issues.	www.csp.org.uk/discharging-cv19-patients www.csp.org.uk/keepactive
Later life training	Promoting physical activity amongst older people: 10-minute online movement classes, three times a day, for older people or those who have been very sedentary and want to ease back into movement and activity.	www.laterlifetraining.co.uk Also archived (available as videos)
Supporting safer home environments	Home Hazards checklist to support people in identifying hazards in their home and taking action to reduce risk has been developed by the Sussex Health and Care Partnership.	British Geriatrics Society website COVID-19 resources page. https://www.westsussex.gov.uk/media/14191/home-environment-checklist-public.pdf
Falls FAQs	In poster format for staff in care homes to support the management of a fall.	https://www.bgs.org.uk/resources/covid-19-tools-and-templates https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes
Keeping well at home	Some people do not have the skills or equipment to engage with some online materials; the Healthy Ageing Research Group at the University of Manchester have developed a physical booklet which includes information about home exercise and nutrition, which can be shared with older neighbours, friends and family.	Keeping well at home booklet
Exposure website	PHE published a blog on 15th June 2020 called 'Health and Wellbeing at Home- Advice and resources for everyone spending more time indoors'. The blog includes a section on 'Preventing falls' where the new resources developed for use during the COVID-19 pandemic, by members of the NFPCG are highlighted (you will need to scroll down to the final paragraph)	PHE's 'Exposure' website

Appendix 1 (continued)

Specific falls-related area	Resource	Source
Active at home	Leaflets have been developed by University of Sheffield to support people remaining 'Active at Home' by providing practical guidance to older adults on home-based activities that will help to maintain their strength and balance.	On PHE Campaign Resource Hub here Local authorities and other organisations can download print ready and digital versions of Active at Home or order physical copies by completing an order from here (please note the link to the order form can be found on the PHE resource hub)
Keeping Well at Home with Gateshead Older People's Assembly (OPA)	For the 140,000+ older people in the region who are not online, a new daily TV programme, Keeping Well at Home with Gateshead OPA started on 30 June 2020.	Episode 1
All Our Health (AOH) Falls and Fractures e-learning	Online AOH topic information on falls and fractures has been.	Updated on Gov.uk website here
Blog: Are you ready for the Autumn and Winter?	Key questions for people providing and planning local falls prevention services during the time of COVID-19.	https://www.bgs.org.uk/blog/are-you-ready-for-the-autumn-and-winter

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