The Prevention and Management of Falls in the Community

A Framework for Action for Scotland 2014/2015

The Scottish Government
Riaghaltas na h-Alba

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FOR CONSULTATION

Version Control

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Introduction

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major and growing concern. A recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million and set to rise over the next decade as our population ages and the proportion with multimorbidity and polypharmacy grows. Less easy to quantify is the impact of falls on an older person's independence and quality of life, and the repercussions for family and friends.

However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting.

Background

Since 2010 the National Falls Programme has aimed to support health and social care partnership areas to implement local integrated pathways which enable a systematic and evidence based approach to falls prevention and management. The model pathway is outlined in the Healthcare Improvement Scotland resource, *Up and About*.

The 2012 report, *Up and About or Falling Short*, presented the findings of a mapping exercise in Scotland which aimed to identify the extent to which recommended practices were embedded in systems of care for older people. The report suggested that although in recent years there has been progress in the implementation of local care pathways for older people who have fallen, there remains variation in service provision and quality in Scotland. An older person's likelihood of being offered evidence based care depends on where and to whom he or she presents following a fall or with a fall-related injury. Opportunities for prevention of falls and fractures are being missed.

The Framework for Action

The Framework for Action builds on the model presented in the Up and About resource, and focuses on falls prevention and management and fracture prevention for older people living in the community. The Framework is underpinned by evidence from research and draws on knowledge and experience gained by the falls prevention community in Scotland over the last four years. It identifies and describes key actions for health and social care services at each of the four stages of the pathway. These actions represent the *minimum* standard of care an older person should expect to receive, regardless of where and when they present to services. The Framework provides a road map for developing or enhancing a falls pathway.

Scotland is a rich source of examples of successful implementation of the majority of these actions. A number of these examples will be available on the Falls and Bone Health Community pages on the Knowledge Network (http://www.knowledge.scot.nhs.uk/fallsandbonehealth.aspx currently under further development).

Development of the Framework for Action
The Framework for Action was developed as part of the National Falls Programme by the National Programme Manager in partnership with CH(C)P Falls Leads representing all partnership areas in Scotland and other key stakeholders. It is informed by recommendations and evidence from current published guidance and research and the tacit knowledge of health and social care professionals with subject matter knowledge and experience.

Assessing where you are
A self assessment tool will be available to enable partnerships to identify the extent to which recommended practices to prevent and manage falls and prevent fragility fractures are embedded in their systems of care for older people. This information can be used to identify progress and potential areas for further improvement.

Policy context

Preventing falls and the harmful consequences of falls contributes to delivering the aspirations, aims and outcomes outlined in a number of key documents, including:

- The National Delivery Plan for the Allied Health Professions in Scotland (2012)
- Co-ordinated, Integrated and Fit for Purpose: the Delivery Framework for Adult Rehabilitation in Scotland (2007)
- Reshaping Care for Older People; A Programme for Change 2010-2021
- Maximising Recovery and Promoting Independence: Intermediate Care's contribution to Reshaping Care (2012)
- Caring Together: The Carers Strategy for Scotland 2010-2011
- Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers (2011)
- National Dementia Strategy 2013-2016
- Healthcare Quality Strategy for NHS Scotland (2011) and the 2020 Vision (2012)

Effective falls prevention and management requires co-ordination and collaboration across health and social care, as well as the third and independent sectors, thus will benefit from an integrated approach to planning and delivering care.

Summary of Actions to achieve the minimum standard for 2014/15

Stage One: Supporting health improvement and self management to reduce the risk of falls and fragility fractures

Action 1.1
Up-to-date information on the prevention of falls and the prevention of harm from falls is made available to older people by health and social care services.

Stage Two: Identifying individuals at high risk of falls and/or fragility fractures

Action 2.1
Health and social care services offer Level 1 assessment† to older people who report a fall or an injury or functional decline caused by a fall.

Action 2.2
Everyone identified at high risk of further falls by Level 1 assessment is offered intervention to identify and address possible contributory factors, i.e. Level 2 assessment†.

Stage 3: Responding to an individual who has just fallen and requires immediate assistance

Action 3.1
Responding services† have a standard operating procedure† for responding to people who have fallen and have *or* have not sustained injuries.

Action 3.2
A responding service attends an older person who has fallen within one hour of being alerted to the fall, or as close to this timescale as possible given geographical constraints.

Action 3.3
Responding services have a standard operating procedure for identifying and meeting the immediate needs of a person who has fallen.

Action 3.4
Health and social care services working with older people in their own homes (including care homes) have a standard operating procedure to identify and meet the immediate need of an older person who falls in their presence or is found on the floor.

Action 3.5
Older people presenting to responding services following a fall and who are not conveyed to hospital, are offered Level 1 assessment†.

Action 3.6
Older people assisted by other health and social care services in the event of a fall, and who are not conveyed to hospital, are offered Level 1 assessment†.

Stage 4: Co-ordinated management including specialist assessment

Action 4.1
Older people identified at high risk of further falls are offered a Level 2 assessment†.

Action 4.2
Health and social care services providing Level 2 assessment have a governance infrastructure to ensure suitable staff undertake Level 2 assessments.

Action 4.3
Following Level 2 assessment the person is provided with a personalised Falls and Fracture Prevention Action Plan.

Action 4.4
Level 3 assessment† and remedial interventions offered are in line with current and emerging evidence.

Action 4.5
Following Level 2 assessment there are referral pathways into services that provide evidence based assessment (Level 3) and intervention.

Action 4.6
Services providing Level 2 assessment can refer directly into services that provide evidence based assessment (Level 3) and intervention.

Action 4.7
There is a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans are implemented.

Stage One: Supporting health improvement and self management to reduce the risk of falls and fragility fractures

Description (taken from Up and About)
At this stage:

- A person is living in the community (including care homes) with support as required.
- The emphasis is on self care, supported self management, health education and promotion.
- Support for carers may be essential to achieve positive outcomes.
- There are opportunities for early intervention if circumstances change, therefore this stage has strong links with anticipatory care.
- Many interventions and activities at this stage contribute to active and healthy ageing generally; some are more specific to falls and fracture prevention.

Actions to achieve the minimum standard for 2014/15

Action 1.1
Up-to-date information on the prevention of falls and the prevention of harm from falls is made available to older people by health and social care services.

Principles

- Information is available in departments, clinics, care homes, day care facilities waiting areas etc, and is also provided on a one to one basis by staff as appropriate.

- The information is in an understandable format suitable to the needs of the person/s receiving it (print size, language etc).

- The information includes:
    - key falls prevention messages (and where to get more detailed/further information), e.g. Age UK's *Top tips for staying steady* or NHS Health Scotland's *Up and About. Taking positive steps to avoid trips and falls* (available from Summer 2014)
    - how to access resources, local services and organisations, which aim to support:
        - the maintenance of health and wellbeing, e.g. exercise/physical activity opportunities
        - a safe home environment, e.g. care and repair services, telecare and community alarm etc
        - a safer community environment, e.g. Dial-a-bus and equivalent services.

- To ensure consistency of message, information provided on falls and fracture prevention and management is based on materials from the following sources:
    - NHS Health Scotland
    - Age UK and Age Scotland
    - The National Osteoporosis Society
    - NHS Inform

Further information

Encouraging positive attitudes to falls prevention in later life: a report for Help the Aged February 2005 Don't mention the F work, Help the Aged

Age UK http://www.ageuk.org.uk/

National Osteoporosis Society http://www.nos.org.uk/

NHS Health Scotland http://www.healthscotland.com/

NHS Inform (under development)

Stage Two: Identifying individuals at high risk of falls and/or fragility fractures

Description (taken from Up and About)
At this stage:

- A person at high risk of falls and fragility fractures is identified and this triggers appropriate intervention, or referral for appropriate intervention.
- A person is identified *either* (a)when they report a fall, or present with a fall or an injury due to a fall, *or* (b)opportunistically when a health or social care practitioner asks about falls.
- Opportunistic case identification links with both anticipatory care and the 'shared assessment' process.
- A level 1 assessment aims to identify individuals at high risk of falling; it is not intended to determine all contributory factors or specific interventions required.

Actions to achieve the minimum standard for 2014/15

Action 2.1
Health and social care services offer Level 1 assessment† to older people who report a fall or an injury or functional decline caused by a fall.

Principles

- A Level 1 assessment, or initial risk identification, aims to identify individuals who have fallen/are at high risk of falling and may benefit from intervention to prevent further falls and restore/retain function following a fall.

- Level 1 Assessment is a simple process, quick to administer and may take the form of a tool or an algorithm. To meet the minimum standard it includes questions about:
  - Frequency and circumstances of the fall/s.
  - Loss of consciousness/blackouts/dizziness at the time of the fall/s.
  - Difficulties with walking or balance.
  - Impact of the fall/s on day to day activities.

Action 2.2
Everyone identified at high risk of further falls by Level 1 assessment is offered intervention to identify and address possible contributory factors, i.e. Level 2 assessment†.

Principles

- A Level 1 assessment tool or algorithm includes clear guidance for the assessor on what steps to take next, based on the findings of the screen.

- The assessor explains to the individual the reason why the intervention is indicated, what this will involve, such as a home visit or clinic attendance, and ensures consent has been given to refer for further assessment.

- There are local referral pathways to services providing Level 2 assessment, and agreed referral protocols.

- For people not referred for further intervention, and those who decline further intervention, up-to-date information is offered on the prevention of falls and the prevention of harm from falls (as described in Action 1.1).

†*Level 1 Assessment*	A simple initial risk identification process which aims to identify individuals who have fallen/are at high risk of falling and may benefit from further assessment and intervention. See Appendix 1 'The falls and fracture assessment continuum' for further information.
†*Level 2 Assessment*	A multifactorial falls risk screening process which aims to (a) identify risk factors for falling and for sustaining a fragility fracture, and (b) guide tailored intervention. See Appendix 1 'The falls and fracture assessment continuum' for further information.

Rationale

A fall is a symptom, not a diagnosis. It can be the first indication of a new or worsening health problem and/or can represent a tipping point, triggering a downward decline in independence. Older adults who fall once are two to three times more likely to fall again within a year[1].

Structuring and standardising the screening process may improve service provider's adherence to guideline recommendations. The use of a small number of simple questions, requiring a yes/no answer, may also simplify documentation. Any positive answer to the screening questions puts the person screened in a high-risk group that warrants further evaluation[2].

In care homes for older people, the recommended practice is for care home staff to carry out a Level 2 assessment routinely on all residents. If this is the case, a level 1 assessment is not required.

For evidence base for actions, see references 1 and 2.

Further information

Managing Falls and Fractures in Care Homes for Older People, produced by the Care Inspectorate & NHSScotland, 2011. Access at:
http://www.scswis.com/index.php?option=com_content&view=article&id=7861:managingfalls-and-fractures-in-care-homes-for-older-people-&catid=246:Consultations&Itemid=570

Stage 3 Responding to an individual who has just fallen and requires immediate assistance

Description (taken from Up and About)
At this stage:

- A person has fallen and has requested or requires immediate assistance.
- The person may have sustained an injury and/or be unwell ***or*** is asymptomatic, appears uninjured but is unable to get up from the floor/ground independently.
- Appropriate onward referral and intervention at this stage may prevent further falls and unwanted consequences of falls.

†In the context of the pathway, *'responding services'* refers to all health or social care services that have designated responsibilities for responding to an older person who has fallen. Responding services include, amongst others, the Scottish Ambulance Service, community alarm/telecare and mobile emergency care services and dedicated falls response services.

Actions to achieve the minimum standard for 2014/15

Action 3.1
Responding services have a standard operating procedure† for responding to people who have fallen and have or have not sustained injuries.

Principles

- There is absolute clarity and agreement amongst all local responding services on arrangements for responding to:
    - injured and/or unwell individuals following a fall.
    - uninjured individuals following a fall.

- NHS 24 is informed of local arrangements for responding to an *uninjured* individual following a fall so it can respond to emergency calls appropriately and in a timely manner.

Action 3.2
A responding service attends an older person who has fallen within one hour of being alerted to the fall, or as close to this timescale as possible given geographical constraints.

Principles

- The timing of the hour starts when the responding service receives the call and stops when the responding service is in attendance.

Action 3.3
Responding services have a standard operating procedure (SOP) for identifying and meeting the immediate needs of a person who has fallen.

Principles

- The SOP covers:
    - assessment for the presence of injury and/or illness and management options,
    - mechanisms for assisting the person safely from the floor.

- Suitable decision support (see below) is available to responding services to ensure individuals who have fallen receive the right care in the right place.

Action 3.4
Health and social care services working with older people in their own homes (including care homes) have a standard operating procedure to identify and meet the immediate need of an older person who falls in their presence or is found on the floor.

Principles
- The SOP covers immediate actions to be taken, including how to gain access to the person's home in an emergency.

- The service will determine appropriate actions for staff to take. This will be based on a number of factors including the nature of the service, the knowledge and skills of staff and the availability of moving and handling equipment.

Action 3.5
Older people presenting to responding services following a fall and who are not conveyed to hospital, are offered Level 1 assessment†.

Action 3.6
Older people assisted by other health and social care services in the event of a fall, and who are not conveyed to hospital, are offered Level 1 assessment†.

Principles
- A Level 1 assessment aims to identify individuals who are at high risk of falling again and may benefit from intervention to prevent further falls and restore/retain function following a fall.

- Level 1 Assessment is a simple process, quick to administer and may take the form of a tool or an algorithm. It includes questions about:
  - Frequency and circumstances of the fall/s.
  - Loss of consciousness/blackouts/dizziness at the time of the fall/s.
  - Difficulties with walking or balance.
  - Impact of the fall/s on day to day activities.

- A Level 1 assessment tool or algorithm includes clear guidance for the assessor on what steps to take next, based on the assessment findings.

- There are local referral pathways to services providing further Level 2 assessment†, and agreed referral protocols.

- For people referred for further intervention, written information is provided to explain what will happen next.

- For people who decline further intervention or are not referred for further intervention, up-to-date information is offered on the prevention of falls and the prevention of harm from falls.

†Standard operating procedure	Standard operating procedures are detailed written instructions to achieve uniformity of the performance of a specific function.

Rationale

This is a critical point in the journey of care. 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 avoidable admission to hospital, functional decline and further falls.

A consultation conducted by NHS Quality Improvement Scotland in 2009[4] identified that there is lack of clarity in some localities around which service should respond to a person who has fallen, is uninjured, but requires assistance to get up from the floor. It was reported that in a number of cases this had resulted in an older person lying on the floor, waiting for assistance for an unacceptable period of time.

The Scottish Ambulance Service will usually be the first point of contact if someone has fallen, is injured or unwell, and requires immediate assistance. It is often less clear which service should respond if a person has fallen, is uninjured but requires assistance to get up from the floor.

A 'long lie' following a fall, defined as remaining on the ground or floor for one hour or more, is associated with serious complications for an older person, including pressure ulcers, kidney damage caused by muscle breakdown, pneumonia, hypothermia, dehydration, and even death. This is regardless of whether or not they have sustained an injury in the fall[5].

Responding services, whether health or social care services, must assess the individual to ascertain (a) the presence of injury and/or illness, and (b) whether or not the individual needs to attend the Emergency Department. If there is not an immediate clinical need, attendance at the Emergency Department may not be in the interests of an older person. In some cases rapid response intermediate care services in the community can provide an alternative to Emergency Department attendance or emergency admission to hospital.

Suitable decision support for responding services will ensure individuals who have fallen then receive the right care in the right place. Decision support takes a variety of forms including algorithms or triage tools, professional to professional support and a range of ehealth solutions such as electronic Emergency Care Summaries and Anticipatory Care Plans.

For evidence base for standards, see references 1, 2 and 6.

Further information

Making the Right Call for A Fall, produced by the Scottish Ambulance Service, the Joint Improvement Team and the National Falls Programme, 2013. Access at: http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4035271/SAS_Making_The%20Right_Call_for_a_Fall_singles.pdf

TSA Good Practice Guide. Telecare Service Providers in Scotland and the Scottish Ambulance Service – working together to improve service delivery. Produced by SCTT, JIT, Scottish Ambulance Service and the Telecare Services Association. Access at:

http://www.telecare.org.uk/publications/telecare-service-providers-in-scotland-and-the-scottish-ambulance-service

Managing Falls and Fractures in Care Homes for Older People, produced by the Care Inspectorate & NHSScotland, 2011. Access at: http://www.scswis.com/index.php?option=com_content&view=article&id=7861:managingfalls-and-fractures-in-care-homes-for-older-people-&catid=246:Consultations&Itemid=570

Stage 4 Co-ordinated management including specialist assessment

Description (taken from Up and About)
At this stage:

- A person has been identified as being at high risk of falling and/or sustaining a fracture.
- Falls risk and fracture risk management are considered in combination, with services for falls and osteoporosis operationally linked or dovetailed.
- Intervention aims to identify, then minimise, a person's risk factors for falling and sustaining a fracture as well as restoring function following a fall/s.
- Before moving from Stage 4 of the pathway, back into Stage 1, interventions have been offered which will support on-going self-management.

Actions to achieve the minimum standard for 2014/15

Action 4.1
Older people identified at high risk of further falls are offered a Level 2 assessment†.

Principle

- The Level 2 assessment will include taking a falls history and screening for risk factors related to:
  - alcohol intake related to the fall/s*
  - cardiovascular and neurological symptoms
  - cognition*
  - fear of falling, anxiety and depression
  - feet and footwear
  - fracture risk
  - function/activities of daily living
  - gait and balance, mobility and muscle strength
  - incontinence including urgency and frequency*
  - medication
  - nutritional status*
  - vision

- Falls history includes:
  - Frequency of falls; how many in past week; month; 12 months.
  - Circumstances of the fall and symptoms at the time of fall.
  - Any loss of consciousness.
  - Injuries and consequences.
  - Ability to get up from floor unassisted.
  - Changes to daily function as a result of falling.

- A Level 2 assessment proforma is a useful tool to reliably identify risk factors and a personalised action plan. Successfully implemented proformas:
  - link risks with suggested remedial actions,
  - include red flags for urgent medical assessment, and
  - are developed by, and agreed with, the local multidisciplinary team.

*Indicates a recommendation not included in published guidelines but agreed by the development group as good practice.

Action 4.2
Health and social care services providing Level 2 assessment have a governance infrastructure to ensure suitable staff undertake Level 2 assessments.

Principles
- Level 2 assessors have the skills, knowledge, understanding and support to undertake their role.
- Assessors' ongoing training and supervision needs are identified and met.

Action 4.3
Following Level 2 assessment the person is provided with a personalised Fall and Fracture Prevention Action Plan.

Principles
- The Fall and Fracture Prevention Action Plan is a tailored multifactorial action plan, agreed with the person (and carers, if appropriate), which addresses risk factors and issues identified in the Level 2 assessment.

- The tailored plan will include:
  - Agreed actions (including actions the person or his/her carer/s have agreed to take, and referrals to other services).
  - Reasons for recommended actions and which service is responsible for which intervention.

- A copy of the Falls and Fracture Prevention Action Plan is provided to the person (and carers, if appropriate)

Action 4.4
Level 3 assessment† and remedial interventions offered are in line with current and emerging evidence.

Action 4.5
Following Level 2 assessment there are referral pathways into services that provide evidence based assessment (Level 3) and intervention.

Principles
- The Falls and Fracture Prevention Action Plan will include one or more of the following elements, dependent on needs identified by the Level 2 assessment.

- Assessment of fracture risk +/- management of osteoporosis.
- Detailed assessment of gait, balance, and mobility levels and lower extremity joint function.
- Strength and balance training, which is individualised, progressive, challenges balance and is of at least 50 hours duration (not all of which need be supervised directly).
- Assessment of the home environment for falls hazards with safety intervention.
- Management of risk associated with feet and footwear.
- Medication review with modification or withdrawal.
- Assessment of activities of daily living (ADL) skills including use of adaptive equipment and mobility aids, as appropriate.

- Therapeutic interventions to improve the person's functional ability and minimise fear of falling.
- Medical assessment where cardiovascular and neurological problems or unexplained falls are identified.
- Assessment and management of visual impairment.
- Education and information provision as part of a tailored multifactorial intervention.
- Continence management.*
- Nutritional assessment and advice.*
- Assessment and management of anxiety or depression.*
- Where cognitive impairment is recognised, referral for ongoing support, and adaptation of the falls plan to reflect the individual's needs.*
- Assessment of telehealthcare needs.*
- Alcohol intervention.*

- Services providing these interventions are identified and there are referral pathways and protocols in place.

*Indicates a recommendation not included in published guidelines but agreed by the development group as good practice.

Action 4.6
Services providing Level 2 assessment can refer directly into services that provide evidence based assessment (Level 3) and intervention.

- To minimise duplication of assessment and remove unnecessary steps in the person's journey of care, there is local agreement that services providing Level 2 assessment have direct access to services delivering falls and fracture prevention interventions.

Action 4.7
There is a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans are implemented.

- There is a reliable process which monitors on a regular basis whether or not interventions recommended in the Falls and Fracture Prevention Action Plan are implemented as planned and agreed, and in line with the person's wishes.

†*Level 3 assessment*	A specialist assessment which aims to assess further the risk factors identified, with a view to providing tailored intervention to reduce the risk of falls and/or fractures. See Appendix 1 'The falls and fracture assessment continuum' for further information.

Rationale

Assessment and intervention
For evidence base for standards, see references 1, 2 and 6.

In 2011, The National Falls Programme Manager consulted with Falls Leads and other subject matter experts in Scotland to identify key components to be included in a set of 'care bundles' being developed for use in the community to prevent recurrent falls. The consultation contributors agreed that multifactorial risk factor *screening* was an appropriate and sustainable first step in the process of identifying and meeting the needs of older people identified as at high risk of falling. Blanket referral of everyone identified at high risk of falls to specialist multifactorial assessment, for example at a Consultant-led clinic, was deemed neither necessary nor feasible. It was agreed that a multifactorial screen tool, developed in collaboration with informed stakeholders and delivered reliably, is capable of identifying the population requiring more specialist intervention.

Further guidance on Level 2 assessment can be found in Appendix 1. This has been taken from the draft *Care Bundles for the Prevention of Recurrent Falls* guidance and information. The content was agreed in consultation with Falls Leads and other subject matter experts in Scotland.

Monitoring and quality assurance
The need for careful monitoring is identified in the AGS/BGS Clinical Practice Guideline. Nine out of ten studies in which assessment and intervention processes were carefully overseen and monitored proved to be beneficial. This contrasted with studies which provided only advice, knowledge or unmonitored referral. Recent trials of multifactorial risk assessment followed by referral without assurance of completion of the intervention have not proven effective[2].

Further Information

Guidelines for the physiotherapy management of older people at risk of falling. Produced by AGILE, Physiotherapists working with older people (2012). Access at: http://agile.csp.org.uk/news/2012/08/16/guidelines-physiotherapy-management-older-people-risk-falling

Falls Management. Produced by the College of Occupational Therapists (2013) Available to buy from: http://www.cot.co.uk/publication/books-z-listing/falls-management

Guideline 71: Management of osteoporosis. Produced by SIGN (2004). Currently being reviewed and updated. Expected Summer 2014.

Managing Falls and Fractures in Care Homes for Older People, produced by the Care Inspectorate & NHSScotland, 2011. Access at: http://www.scswis.com/index.php?option=com_content&view=article&id=7861:managingfalls-and-fractures-in-care-homes-for-older-people-&catid=246:Consultations&Itemid=570

Measurement Plan

A suite of core improvement measures has been developed to support Partnerships, services and teams to track their progress in implementing the Framework for Action. These core measures will help service providers to understand their local systems and the steps required to improve processes, effectiveness and outcomes of care and support.

Measurement is an essential component of quality improvement. The Framework for Action improvement measures have been designed to focus attention at key points along the Up and About pathway. Both outcome and process measures have been included. They should be fully integrated into local service improvement work and will contribute to the wider performance management and reporting.

Measurement plan

Process measures (local data)				
ID	**Measure name**	**Count** *Operational definition*	**% of all people presenting or attending following a fall.** *Operational definition*	**Rate per 1000 population aged 65+** *Operational definition*
P1	Level 1 assessments completed	**The sample: a**ll people who have had a L1 assessment completed (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had a L1 assessment completed.	**The sample:** all people who have had a L1 assessment completed (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample.

			Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.
P2	Referrals made for L2 assessment	**The sample:** all people who have been referred for L2 assessment. (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who were referred for L2 assessment. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	**The sample:** all people who have had a referral made for L2 assessment. (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.
P3	Level 2 assessments completed	**The sample:** all people who have had a L2 assessment completed (in the measurement period). **Calculating the measurement:** **Count** the number of people	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:**	**The sample:** all people who have had L2 assessment completed (in the measurement period). **Calculating the measurement:** **Determine the denominator:**

		in the sample.	the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had a L2 assessment completed. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.
P4	Individualised management plans agreed.	**The sample:** all people who have had an individualised management plan agreed (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. The total number of patients/clients in the sample with whom an individualized management plan was agreed (as defined in the FfA) the sample referred for L2 assessment.	**The sample:** all people presenting/attending following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who had an individualised measurement plan agreed. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100.	**The sample:** all people who have had an individualized measurement plan agreed (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000.

Outcome measures (national, NHS board area and CH(C)P level)				
ID	**Measure name**	**Count** *Operational definition*	**% of all people conveyed following a fall** *Operational definition*	**Rate per 1000 population aged 65+** *Operational definition*
O1	Conveyances to hospital by the Scottish Ambulance Service (SAS) following a fall (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ conveyed to hospital by the SAS following a fall (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. *Data source: Data Warehouse (SAS)*	**The sample:** all people aged 65-74, 75-84, 85+ presenting to the SAS following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people in the sample. **Determine the numerator:** the total number of people in the sample who were conveyed to hospital by the SAS. Calculate the percentage by dividing the numerator by the denominator and then multiplying the result by 100. *Data source: Data Warehouse (SAS)*	**The sample:** all people 65-74, 75-84, 85+ conveyed to hospital by the SAS following a fall (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65+ in the population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. *Data source: Data Warehouse (SAS)*
O2	Emergency admissions following a fall (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital following a fall (in the measurement period).		**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital following a fall (in the measurement period).

		Calculating the measurement: **Count** the number of people in the sample. *Data source: SMR01 (ISD)*		**Calculating the measurement:** **Determine the denominator:** the number of people aged 65-74, 75-84, 85+ in the population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. *Data source: SMR01 (ISD)*
O3	Admissions with a hip fracture (people aged 65-74, 75-84, 85+).	**The sample:** all people aged 65-74, 75-84, 85+ with an emergency admission to hospital with a hip fracture (in the measurement period). **Calculating the measurement:** **Count** the number of people in the sample. *Data source: SMR01 (ISD)*		**The sample:** all people aged 65-74, 75-84, 85+with an emergency admission to hospital with a hip fracture (in the measurement period). **Calculating the measurement:** **Determine the denominator:** the number of people aged 65-74, 75-84, 85+ in the local population. **Determine the numerator:** the number of people in the sample. Calculate the rate by dividing the numerator by the denominator and then multiplying the result by 1000. *Data source: SMR01 (ISD)*

References

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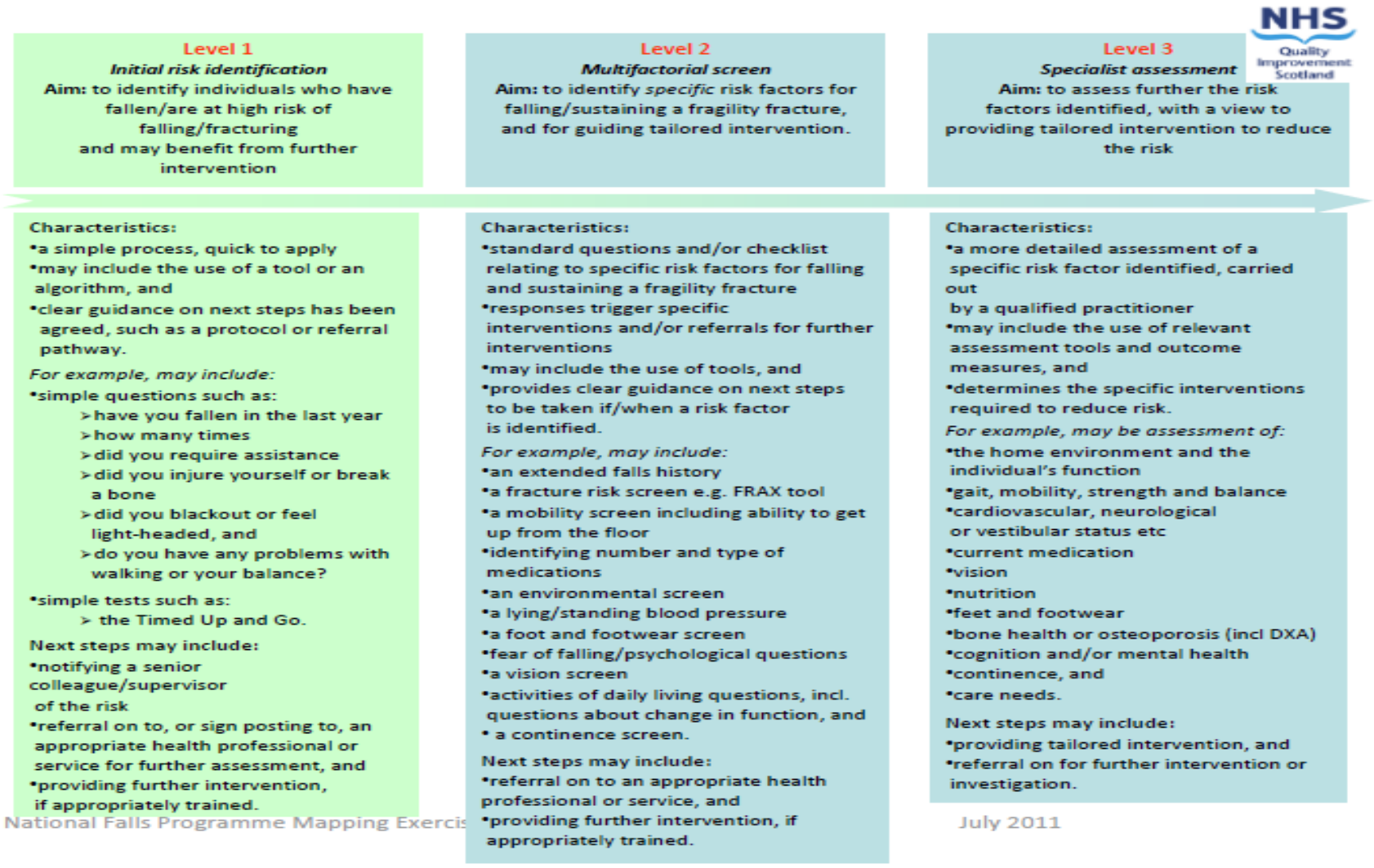
Appendix 1: the falls and fracture risk assessment continuum



Appendix 2

Further guidance on Level 2 assessment

Recommendations for Level 2 Assessment (Multifactorial screen)	
Assessment component	**Additional information:**
Gait and balance, mobility and muscle strength	*Suggestion* A simple test such as the Timed Up and Go or the Up and Go will provide the opportunity to observe difficulties with standing from sitting, balance, walking, turning and sitting down.
Fear of falling	*Suggestion* If you would like to use an assessment tool as part of the screen, the Falls Efficacy Scale- International is validated.
Cognitive impairment	Abbreviated Mental Test is commonly used.
Cardiovascular symptoms	*Suggestion* • Enquire about existing heart problems including arrhythmias, valve disease, palpitations • Ask about any blackouts, or light-headedness when standing from lying/sitting • Consider checking lying to standing BP if the assessor is trained, competent and has suitable equipment
Neurological symptoms	*Suggestion* • Identify problems with co-ordination and balance while screening gait and balance (see above) • Enquire about loss of sensation.
Medication	*Consider:* • polypharmacy • types of medications • compliance with medication • reason for non-compliance . Agree the screening/trigger questions locally with the service or professional the assessor will be referring on to, such as the GP, pharmacist or falls clinic etc.
Nutritional status	*Consider:* weight loss and chewing problems.

ANNEX

The Prevention and Management of Falls in the Community
A Framework for Action for Scotland 2014/2015

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ ***Please tick as appropriate***

Surname

Forename

2. Postal Address

Postcode	**Phone**	**Email**

3. Permissions - I am responding as…

Individual ☐ / **Group/Organisation** ☐

Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation ***will be*** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your ***response*** to be made available?

Please tick as appropriate ☐ **Yes** ☐ **No**

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☐ **Yes** ☐ **No**

Responding to this Consultation Paper

We are inviting written responses to this consultation paper by **16 June 2014**. Please send your response with the completed Respondent Information Form (see "Handling your Response" below) to:

CNOPPPAdmin@scotland.gsi.gov.uk

Or by post to:
Julie Townsend
Scottish Government Health Directorate
Directorate for Chief Nursing Officer, Patients, Public and Health Professions
GE 19, St Andrew's House
Regent Road
Edinburgh
EH1 3DG

If you have any queries please contact Julie Townsend on 0131 244 3739.

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations.
.

The Scottish Government has an email alert system for consultations, http://register.scotland.gov.uk. This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). It complements, but in no way replaces Scottish Government distribution lists, and is designed to allow stakeholders to keep up to date with all Scottish Government consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form which forms part of the consultation questionnaire attached an annex as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation.

Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library (see the attached Respondent Information Form). These will be made available to the public in the Scottish Government Library by 16th June 2014. You can make arrangements to view responses by contacting the Scottish Government Library on 0131 244 4556.

Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the content of the final framework for action.

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