Proactive Management of person at risk of Falls in the Community

See pathway Falls Risk Identification in the Community

Individual identified as at risk of falls

Low risk
- Self-management advice and care planning
- Exercise – strength and balance

Low – moderate risk
- Use level 1b step-by-step guide
- Self-management advice and care planning
- Exercise – strength and balance

Moderate – high risk
- Refer to specialist services as required/appropriate (e.g. dementia)
- Community falls and frailty hub to co-ordinate pathways – to include co-ordination of Clinical Multifactorial Assessment (MFA)
- Manage identified risk factors

Imminent risk
- See pathway Acute Urgent/Emergency Falls Pathway

Reflect identified as at risk of falls

Self-management advice and care planning
- Refer to secondary care if complex needs requiring specialist input

Specialist input required to assess and manage risk?

- YES
  - Exercise – strength and balance
  - Onward care planning

- NO
  - Exercise – strength and balance

Refer to specialist services as required/appropriate (e.g. dementia)

Manage identified risk factors

Community falls and frailty hub to co-ordinate pathways – to include co-ordination of Clinical Multifactorial Assessment (MFA)

See pathway Acute Urgent/Emergency Falls Pathway

Self-management advice and care planning
- Exercise – strength and balance

Click for more info for care homes

Click for more info

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Click for more info
**Low risk**

For example (all of the following dependant on how many assessments are carried out):

- Over the age of 65 - no history or immediate risk of falls identified. Not yet fallen
- Scores 0 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- No concerns about person’s falls risk
- No indication of frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.
Self-management information

The following actions can be completed by anyone:

Signpost to:
- Get up and Go leaflet: http://www.csp.org.uk/publications/get-go-guide-staying-steady
- Your step-by-step guide to staying independent and preventing falls (Hertfordshire) - INSERT LINK – this is a local guide to health and social care resources that can help people stay independent

Further assessment (as appropriate by a clinician):
- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see identification of Frailty pathway)
- Carers assessment as appropriate – refer to appropriate service
- Postural hypotension assessment

Health and Social Care professionals to consider social prescribing and assessing loneliness as appropriate

Social prescribing
- Signpost to voluntary/third sector for support (e.g. HILS, Age UK)
- Promote the concept of the patient volunteering (helps loneliness wellbeing, physical activity) – signpost/ help to find opportunities to volunteer
- Advice on keeping warm
- Signpost to social opportunities (e.g. lunch clubs, local older people's groups, digital inclusion)
- Signpost to physical activities opportunities – consider exercise on referral and falls prevention
- Consider Anxiety and if required signpost to local Wellbeing Service

Signpost to Herts Help (Hertfordshire) or Living Well (West Essex)
HertsHelp: https://www.hertshelp.net/hertshelp.aspx

Contact us
Phone: 0300 123 4044
Email: info@hertshelp.net
Skype: HertsHelp
Text: hertshelp to 81025
Minicom: 0300 456 2364
Fax: 0300 456 2365
BSL: https://www.signbsl.com/

Living Well Essex: https://www.livingwellessex.org/
Contact us
Phone: 03457 430 430 or 01245 430 430
Textphone: 0345 758 5592
Email: contact@essex.gov.uk
Opening hours are 8.30am-5pm Monday to Friday.

Loneliness assessment

A number of tools are available. The UCLA Loneliness scale is described below. Staff may require training and support to ask negatively worded questions sensitively.

This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The scale generally uses three response categories: Hardly ever / Some of the time / Often

Using this scale: how to score and interpret your results

In order to score somebody's answers, their responses should be coded as follows:

Response score for each question
Hardly ever = 1
Some of the time = 2
Often = 3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.

People who score 3 – 5 are usually classed as “not lonely”
People with the score 6 – 9 are usually classed as “lonely”
Exercises should be done under the supervision of a healthcare professional. If you experience chest pain or feel faint whilst exercising, stop immediately and contact your healthcare professional. If you feel very unwell, for example chest pain does not stop despite resting, call 999.

If the person is in a care home, the care officer must ensure that the person has access to strength and balance exercise.

Unless clinically contraindicated recommended:
- Regular gentle approach to exercise
- 10-20 minute moderate activity a day
- Strength exercises two or more days a week
- General exercise such as walking, swimming, cycling, and yoga

Recommended activities
- Self-management and advice
- Signed to the care plan and exercise advice (if contraindicated)
- Exercise guidelines and physical activity through public, private, voluntary, and third sector providers, e.g., Tai Chi
- Signed to NCS Help (Tai Chi) or Living Well (Tai Chi) for local exercise opportunities

Contact us:
- Phone: 0800 623 4830
- Email: info@hertshelp.net
- Visit: hertshelp.net

Living Well is: [https://livingwellessex.nhs.uk/]
Contact us:
- Phone: 01621 546 610 or 01345 608 500
- Telephone: 01264 750 500
- Email: contact@livewell.org

Opening hours: Monday to Sunday

Other information about health and care services available:
- Healthwatch Essex
- Contact: 0300 500 1895

*Available contra-indications to exercise*

There are also several contra-indications to exercise which on exercising professional should be familiar with, see list below. Patients with absolute contraindications should not exercise until such conditions are stabilised in adequately treated.

Absolute contra-indications to exercise
- Any recent significant change in chest pain during exercise or history of angina pectoris or myocardial infarction
- Hypertensive severe cardiac disease
- Acute myocardial infarction
- Myocardial infarction percutaneous transluminal coronary angioplasty (PTCA)
- Unstable angina
- Acute uncontrolled psychiatric illness
- Acute uncontrolled diabetes mellitus
- Hypoglycaemia significant drop in BP during exercise
- Hypertensive retinopathy, visual field defect
- Visual field defect
- Exertional pulse, dizziness or excessive breathlessness during exertion
- Any uncontrolled, uncontrolled condition

*Contra-indications to exercise*

- *10 Signs*: This sign should be provided either by the patient's cardiologist or nurse. Rehabilitation team

- *Diabetes*: Beyond an exercise here as exercise can be harmful to those without the uncontrolled diabetes

High risk

Referral patients categorised as high risk in the risk stratification for appropriate supervised physical activity

Factors
- Cardiac: stable angina with no chest pain at rest, myocardial infarction, coronary artery bypass graft, valve replacement, pacemaker, percutaneous transluminal coronary angioplasty (PTCA)
- Diabetes: diagnosed by cardiologist
- Hypertension: moderate hypertension with BMI 27-29 kg/m²
- Cancer: diagnosed by cardiologist
- Age: over 65 years of age, frail, has fallen within the last 2 months
- Other: hypertension: BMI ≥ 30 kg/m²

Conditions
- Cardiac: diagnosed by cardiologist
- Hypertensive severe cardiac disease
- Diabetes: diagnosed by cardiologist
- Hypertension moderate hypertension with BMI 27-29 kg/m²
- Cancer: diagnosed by cardiologist
- Age: over 65 years of age, frail, has fallen within the last 2 months

Contra-indications
- Any recent significant change in chest pain during exercise or history of angina pectoris or myocardial infarction
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- Hypertensive retinopathy, visual field defect
- Visual field defect
- Exertional pulse, dizziness or excessive breathlessness during exertion
- Any uncontrolled, uncontrolled condition

Please follow links to PDF version with active links

*Falls framework for postural stability and exercise in older adults*

- Tai Chi
- Signpost HertsHelp
- Signpost HertsHelp
- Other information about health and care services available
- Healthwatch Essex
- Contact: 0300 500 1895

*An exercise prescription example*
**Low – moderate risk**

For example (all of the following dependant on how many assessments are carried out):

- Mild deficit in strength and balance
- No more than 1 fall in last 12 months - judged at low risk of *recurrent* falls
- Reduced confidence
- Score 1-2 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- Mild concerns about person’s falls risk
- No indication of frailty, or indication of mild frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.
Level 1b - Step-by-step guide to staying independent and preventing future falls in Hertfordshire (LINK)

In people who have some falls risks identified (e.g. FRAT 1-2), the step-by-step guide can be used to look more specifically at risk factors and advise on next steps.

The step-by-step guide can be used by all (including self-assessment).

If the person is unable to complete it themselves, they can be guided through it with help from anyone.

If multiple risks of falls are identified using 1b step-by-step guide requiring further input from a health care professional, please refer to the Falls and Frailty hub

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral.

In all people:

Record:
Document the outcome of the assessment. Keep a list of people identified as being at risk of falls.
If the patient has a care plan folder, please document in here the assessment including date and outcome.

Follow up
Have a plan in place to ensure the individual has their falls risk assessed regularly

Please follow hyperlink for PDF version with active links

Your step-by-step guide to staying independent and preventing falls

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>If Yes*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you feel dizzy or lightheaded? Have you experienced any unexplained symptoms?</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Have you fallen more than twice in the last 6 months?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are you taking more than 4 regular medicines? This includes over the counter medicines.</td>
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</tr>
<tr>
<td>3</td>
<td>Do you have an illness like Parkinson’s, MS or a stroke that has left you with poor movement?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Are you unsteady on your feet or have concerns about your balance?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Have you broken any bones after the age of 50 &amp; not had a recent bone health check?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you feel dizzy or lightheaded at times? For example when you move from lying to sitting or when you stand up.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are you unable to get up from a dining room style chair, without using your arms?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you drink more than the recommended limit of alcohol ($4 units a week over 3 days or more)? Do you use alcohol to help you sleep or control pain?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you get about less than you would like because you are worried about slipping, tripping or falling?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you find it hard to be regularly active? The recommendation is 30 minutes, 5 times a week e.g. gardening, vigorous housework, cycling and daily walks.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Have your eyes tested in the last 24 months?</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you have any problems with your bladder or bowel? For example, do you need to get up in the night to go to the loo?</td>
<td></td>
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<tr>
<td>13</td>
<td>Does your home have trip hazards, for example, loose mats or cluttered walkways or poorly lit stairs?</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you drink less than six to eight cups of fluid each day? (fluid includes any non-alcoholic drink e.g. water, fruit juice, tea, coffee and milky drinks)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you have difficulty taking care of your feet?</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you have difficulty taking care of your feet?</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Do you know what to do if you had a fall?</td>
<td></td>
</tr>
</tbody>
</table>

For tips and details on how you can prevent falls, please read the Get up and Go leaflet, you can find this online or ask a Health & Social Care Professional for a paper copy.
The following actions can be completed by any professionals involved in the person’s care:

Signpost to:
- Get up and Go leaflet: http://www.cog.org.uk/publications/get-go-guide-staying-steady
- Consider giving STP Aged Well resource pack
- Regular sight and hearing checks
- Health promotion advice
- Technology innovations e.g. pendant alarms, telehealth care solutions (may be eligible for council schemes)

Raise awareness of:
- Eating well and staying hydrated: https://www.nhs.uk/conditions/dehydration/
- Home hazards and wearing the correct footwear
- Skin health – recommend regular moisturising
- What to do if the person has a fall – see Get up and Go leaflet for more information
- Local and National campaigns that occur at different times of the year e.g. Slipper’s Swap campaign
- Appropriate foot care
- Staying active

Further assessment (as appropriate):
- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see identification of Frailty pathway)
- Carers assessment as appropriate – refer to appropriate service
- Postural hypotension assessment
- Safe and well fire service checks

Health and Social Care professionals to consider social prescribing and assessing loneliness as appropriate

Social prescribing
- Signpost to voluntary/third sector for support [e.g. HLS, Age UK]
- Promote the concept of the patient volunteering (helps loneliness wellbeing, physical activity) – signpost/ help to find opportunities to volunteer
- Advice on keeping warm
- Signpost to social opportunities (e.g. lunch clubs, local older people’s groups, digital inclusivity)
- Signpost to physical activities opportunities – consider exercise on referral and falls prevention
- Consider Anxiety and if required signpost to local Wellbeing Service
- Signpost to Herts Help (Hertfordshire) or Living Well (west Essex)

HertsHelp: https://www.hertshelp.net/hertshelp.aspx

Contact us
Phone: 0300 123 4044
Email: info@hertshelp.net
Skype: hertshelp
Text: hertshelp to 81025
Minicom: 0300 456 2364
Fax: 0300 456 2365
Blind: https://www.signbol.com/

Living Well Essex: https://www.livingwellesssex.org/
Contact us
Phone: 0345 743 430 or 01245 430 430
Textphone: 0345 758 5592
Email: contact@essex.gov.uk
Opening hours are 8.30am-5pm Monday to Friday.

Loneliness assessment
A number of tools are available. The UCLA Loneliness scale is described below. Staff may require training and support to ask negatively worded questions sensitively.

This scale comprises 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation. The questions are:

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The scale generally uses three response categories: Hardly ever / Some of the time / Often

Using this scale: how to score and interpret your results
In order to score somebody’s answers, their responses should be coded as follows:

Response score for each question
- Hardly ever = 1
- Some of the time = 2
- Often = 3

The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.

People who score 3 – 5 are usually classed as “not lonely”
People with the score 6 – 9 are usually classed as “lonely”

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The scores for each individual question can be added together to give you a possible range of scores from 3 to 9.

People who score 3 – 5 are usually classed as “not lonely”
People with the score 6 – 9 are usually classed as “lonely”
Exercise – strength and balance

Exercise is an important part of falls risk reduction; however, certain health conditions and individual fitness levels need to be considered before making a recommendation to exercise. The contraindications outlined indicate some of the conditions to be aware of; however, if in doubt, recommended the person seeks professional advice before commencing a new exercise program.

Anyone recommending exercise should follow the following advice:

Make sure that any exercise classes, or exercises described in guides or videos, are suitable for you and that you feel comfortable doing the exercise. If you’re not sure, or if you have a heart condition or haven’t been exercising regularly, speak to your healthcare professional first about what activities might suit you.

If you experience chest pain or feel faint whilst exercising, stop exercising immediately and contact your healthcare professional. If you feel very unwell, for example chest pain does not subside or onset = call 999.

If the person is in a care home, the care team must ensure that the person has access to strength and balance exercise.

Unless clinically contraindicated, recommend:

- Utmost approach to exercise
- Minimum of 5 times per week
- Balance and coordination class at least 2 days a week.

Please see here for exercise advice for severe psychiatric illness (see list above).

Recommended activities:

Exercise contraindicated based on identified need:
- Individually self-management
- • COPD, positive movement and older people exercise class
- • Long-Term Conditions (specific class)
- • MODADDY / Psychiatric disability.

Absolute contra:

- COPD
- Older people
- Hypertension
- Cardiac, if the person is in a care home
- Uncontrolled resting tachycardia ≥ 100
- Resting Systolic Blood Pressure ≥ 180
- Any unstable cardiac conditions
- Acute uncontrolled psychiatric illness
- Uncontrolled diabetes
- Uncontrolled stable angina
- Uncontrolled heart failure
- Symptomatic severe aortic stenosis
- Asymptomatic severe emphysema
- If you experience chest pain does not subside on resting
- If you have a heart condition or haven’t been exercising regularly, speak to your healthcare professional first about what activities might suit you.

Exercise is an important part of falls risk reduction.

Minimum of 1 hour per week
- Strengthening (e.g., OTAGO approach to exercise)
- Maintenance of muscle strength
- Lifelong physical activity

Patients with recent myocardial infarction or other acute cardiac event:
- Limited to specific exercises (i.e., walking exercise)
- Uncontrolled resting systolic blood pressure ≥ 180
- Uncontrolled systolic blood pressure ≥ 100
- Uncontrolled diastolic blood pressure ≥ 100
- Uncontrolled heart failure
- Symptomatic severe aortic stenosis
- Asymptomatic severe emphysema
- If you experience chest pain does not subside on resting
- If you have a heart condition or haven’t been exercising regularly, speak to your healthcare professional first about what activities might suit you.

Exercise is an essential part of falls risk reduction.

Lifelong physical activity
- Strengthening (e.g., OTAGO approach to exercise)
- Maintenance of muscle strength
- Lifelong physical activity

See list for PDF version with active links.
Moderate – high risk

For example (one or more of the following dependant on how many assessments are carried out):

- Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk
- Mild deficit in strength and balance plus cognitive/ motivational issue
- Score 3 or above on the Falls Risk Assessment Tool (FRAT)
- >12 seconds result on Timed up and Go (TUG)
- Indication of postural hypotension
- Concerns about person’s falls risk
- Indication of mild, moderate or severe frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral. Please use clinical judgement as required.
Community falls and frailty hub to co-ordinate pathways – to include co-ordination of Clinical Multifactorial Assessment (MFA)

Multi-factorial assessment by multidisciplinary clinical team in community e.g. Physiotherapists, Occupational Therapists, GPs, Geriatricians including support when required from other professionals such as Pharmacists, Opticians etc.

The MFA should be co-ordinated by the falls and frailty hub who should send the right person/people to complete any assessments and plan the next steps.

Discuss with patient
- Falls history
- Perceived functional ability/fear of falling
- Osteoporosis risk factors/assess risk
- Urinary symptoms and continence
- Dizziness or light-headedness
- Levels of physical activity

Examine the patient
- Gait, balance and mobility, and muscle weakness
- Neurological examination and cognition
- Cardiovascular examination including postural blood pressure
- Vision and hearing
- Skin health/Tissue viability

Review contributory factors
- Medication review
- Home hazards and footwear
- Nutrition and hydration
- Long-term conditions and co-morbidities
- Foot care

Medical Intervention
If the risk of falls for an individual is felt to be due to medical issues (for example: postural hypotension or medication issues), the hub should consider onward referral e.g. pharmacist or GP, or a specialist review (secondary care) for highly complex patients.
Manage identified risk factors

This needs to be completed by a clinician. However, the interventions may be completed by more than one clinician involved in the person’s care.

Multifactorial interventions

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal
As part of the clinical assessment, the patient should be risk stratified for their safety to exercise

**Absolute contra-indications to exercise:**
- A recent significant change in a resting ECG, recent myocardial infarction or other acute cardiac event
- Symptomatic severe aortic stenosis
- Acute myocarditis or pericarditis
- Resting Systolic Blood Pressure ≥ 180mmHg or DBP ≥ 100mmHg
- Uncontrolled or unstable angina
- Acute uncontrolled psychiatric illness
- New or uncontrolled arrhythmias
- Experiences significant drop in BP during exercise
- Uncontrolled resting tachycardia > 100 bpm
- Fabry’s illness
- Experiences pain, dizziness or excessive breathlessness during exertion
- Any untestable, uncontrolled condition

**Appropriate guidance on this should be provided either by the patient’s cardiologist or cardiac rehabilitation team**

**Diabetes may be an exception here as exercise can help individuals** in the management of uncontrolled Diabetes

*If the patient is at high risk* of exercise, consider specific intervention

If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.

**Unless clinically contraindicated recommend:**
- 50 hours (3 hours per week - 1 hour per class or 2 hours independently). Arrangements for maintaining and review post course completion
- Recommendation can depend on the individual needs, capacity & ability
- Lifelong approach to exercise

**Recommended activities:**
- Exercise continuum based on identified need:
  - Individualised self-management programme
  - Individualised strength and mobility exercises if unable to begin balance exercises / PSI/OTAGO
  - Community OTAGO/Postural Stability programme
  - Home-based OTAGO programme
  - Home-based Physio/OT

**Signpost to NHS livingWell – exercise for older adults:** [https://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-older-adults.aspx](https://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-older-adults.aspx)

**Signpost to Herts Help (Hertfordshire) or Living Well (Essex) for local exercise opportunities**

**HertsHelp:** [https://www.hertshelp.net/hertshelp.aspx](https://www.hertshelp.net/hertshelp.aspx)

**Contact us:**
- Phone: 0300 123 4044
- Email: info@hertshelp.net
- Skype: HertsHelp
- Text: hertshelp to 81025
- Minicom: 0300 456 2364
- Fax: 0300 456 2365
- BSL: [https://www.signbsl.com/](https://www.signbsl.com/)

**Living Well Essex:** [https://www.livingwellsex Essex.uk.com](https://www.livingwellsex Essex.uk.com)

**Contact us:**
- Phone: 03457 430 430 or 01245 430 430
- Telephone: 0345 758 5592
- Email: contact@essexpal.org.uk
- Opening hours are 8.30am-5pm Monday to Friday.

**Other information about health and care services available:** [Healthwatch Essex Information Service](https://www.0300 500 1895)

**High risk**

**Refer patients categorised as high risk in the risk stratification to appropriate supervised physical activity**

**Factors**
- Cardiac: Stable angina with no chest pain at rest, myocardial infarction, coronary artery bypass graft, valve replacement, pacemaker, percutaneous transluminal coronary angioplasty, heart failure
- Cardiac arrhythmias - diagnosed by cardiologist
- Hypertension - mediated but with BP of 160-180/95-100 mmHg
- Transient ischaemic attack - with severe disability/cognitive impairment
- Older people > 65 years at risk of falls - has fallen within the last 12 months
- Osteoporosis - BMD T score < 2.5 SD
- Diabetes: with associated microvascular complications
- Moderate to severe osteoporosis - where ventilatory limitation restrains sub-maximal exercise
- COPD/emphysema - with true ventilatory limitation
- Severe psychiatric illness - cognitive impairment, dementia, schizophrenia
- AIDS - with accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection

**Please follow [hyperflex](hyperflex) for PDF version with active links**

**Falls framework for postural stability and exercise in Hertfordshire**

<table>
<thead>
<tr>
<th>PSS &amp; PA - Low risk of fall</th>
<th>Low moderate risk of fall</th>
<th>Moderate high risk of fall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Descriptive</strong></td>
<td>Wild deficit in strength and balance. No more than 1 fall in last 12 months. Reduced confidence judged at four points of recurrent falls</td>
<td>Recurrent falls, recent significant fear of falling, losses with strength, balance or gait contributing to risk</td>
</tr>
<tr>
<td><strong>Assessment Options</strong></td>
<td><strong>FITAT</strong></td>
<td><strong>Your step-by-step guide to staying independent: preventing falls in Hertfordshire</strong></td>
</tr>
<tr>
<td></td>
<td><strong>OTOGO</strong></td>
<td><strong>Quantitative Tied up and go (OTT)</strong> / Tied up and go (TUG) (optional)**</td>
</tr>
<tr>
<td></td>
<td><strong>Multifactorial assessment (optional)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**When would refer**
- OT
- Physio
- Social worker
- Other

**Who would refer**
- Health and Social Care Professionals/ Other Community Professionals

**Actually**
- Self-management and advice
- Signpost to HertsHelp for local exercise opportunities
- Signpost to BMD T score (osteoporosis) exercise/benefit/costs
- Signpost to the OTOGO exercise/benefit/costs
- Signpost to the OTOGO exercise/benefit/costs
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- Signpost to the OTOGO exercise/benefit/costs

**Exercise continuum based on identified need**
- Individualised self-management
- Tied up: positive movement and other exercises
- Tied up: postural stability programme
- Lifting from bed: specific client’s needs
- OTOGO: postural stability classes
- Home-based Physio/OT

**Total**
<table>
<thead>
<tr>
<th>Regular life for exercise: strength and balance exercises - rescue pack</th>
<th>Minimum of 1 to 2 hours per week</th>
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**Additional recommended activities**
- Exercise continuum based on identified need
- Individualised self-management programme
- Tied up: positive movement and other exercises
- OTOGO: postural stability programme
- Home-based Physio/OT

**Note:** An evidence-based e-consult programme is to support lifelong, moderate intensity, general fitness and well being.
Self-management advice and care planning

The following actions can be completed by any professionals involved in the person’s care:

Care planning information
- Discuss individuals interests and priorities
- Signpost to community organisations relevant to persons’ preferences including exercise opportunities
- Use STP care plan documentation – start / maintain / update as appropriate
- Identify informal carers and record on clinical record and patient held care plan
- Agree self-management goals and actions with person if appropriate

Self-management information

Signpost/refer to:
- STP Ageing Well resource pack (this will include Get up and Go leaflet: [http://www.csp.org.uk/publications/get-go-guide-staying-steady](http://www.csp.org.uk/publications/get-go-guide-staying-steady))
- Your step-by-step guide to staying independent and preventing falls (Hertfordshire) INSERT LINK – this is a local guide to health and social care resources that can help people stay independent
- Technology innovations e.g. pendant alarms, telehealth care solutions (may be eligible for council schemes)
- Consider Anxiety and if required signpost to local Wellbeing Service

Raise awareness of:
- Eating well and staying hydrated - [https://www.nhs.uk/conditions/dehydration/](https://www.nhs.uk/conditions/dehydration/)
- Home hazards and wearing the correct footwear
- Skin health – recommend regular moisturising
- What to do if the person has a fall – see Get up and Go leaflet for more information
- Local and National campaigns that occur at different times of the year e.g. Slipper’s Swap campaign
- Appropriate foot care
- Staying active

Further assessment (as appropriate):
- Recommend an annual medication review. For clinicians, this may include a polypharmacy review – use STOPP START methodology (ideally in clinical system)
- Assess for risk of frailty (see Identification of Frailty pathway)
- Postural hypotension assessment
- Cognitive assessment
- Carers assessment – refer to appropriate service
- Home environment assessment for aids/adaptations and equipment
- Safe and well fire service checks
Imminent risk

Immediate risks/acutely unwell:
- Manage any immediate risks within your capability and competence.
- Escalate any concerns

If not in immediate danger requiring urgent review then ALL people should be referred for a clinical multi-factorial risk assessment.

If the person is identified as high risk of falls (high score on the FRAT or clinical concerns), they should be referred to Community Trust (predominantly mobility and balance concerns) or their GP (predominantly medical concerns e.g. condition specific, medication).

If a falls and frailty hub is available, the person should be referred there to be appropriately triaged for ongoing management.
Information for care homes

- Individuals living in care homes and other residential settings, should have equal access and opportunity to all risk tools and assessments (as appropriate for them).

- If the person is in a care home, the care home must ensure that the person has access to strength and balance exercise.

- For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present.

- Presence of additional needs should not be a barrier to assessing a person for frailty or falls.

- Contact local Care Providers association for details of local support and training packages available e.g. Hertfordshire Care Providers Association has launched the Stop Falls Campaign for Health and Social care staff across Hertfordshire, funded by Hertfordshire County Council. The campaign aims to increase knowledge on minimising risk and understanding how to assess clients at risk of falls in social care settings, by upskilling staff through education and our ‘Top Tip’ Resource packs. To view our materials visit www.hcpa.info/stopfall