London: Virtual Ward Falls Pathway for patients living with frailty

Version 1.2

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This document will be reviewed and re-released to reflect new and emerging evidence as appropriate. Please email england.londoncagsupport@nhs.net to request the most recent version.

This London guide is designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published.

NHS England London

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Catherina Nolan on Catherina.Nolan@nhs.net.

Contents

Background

Across London, the median number of people over the age of 65 years conveyed to hospital with a coded fall is 4,539 per month*. Falls is the top reason for admissions for people living with dementia within London followed by urinary tract infection. Itself often a reason for a fall. Falls is a condition that has a myriad a ways of coding with no concistent method in use. Therefore identifying the exact number of patients admitted into hospital as a result of fall is a current challenge. The data that is available give us an understanding of the weight of the numbers but does not reflect all falls. Nevertheless, it is a common reason for admission in over 65 year olds and often sits alongside multi morbidity and multi complexity.*(Taken from LAS data oct2021-Oct2022)

Falls in over 65 year olds have a negative impact on functional ability, independence and increased link with multi morbidity, mortality increased costs of healthcare and quality of life.[1]

Virtual ward care is the provision of intensive high acuity level care that would traditionally be provided in a hospital inpatient setting.
'*A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital*

NB: A virtual ward is not a mechanism intended for enhanced primary care programmes; chronic disease management; intermediate or day care; safety netting; proactive deterioration prevention; or social care for medically fit patients for discharge'[2]

Virtual ward has the ability to dovetail with existing services in same day emergency care (SDEC) and urgent community response (UCR). Increasingly, in contrast to the above definition of virtual ward care, services in London are delivering virtual ward services in a setting other than the patient's own home e.g. step-down facility or care home etc.

How to Use this Document

This document is aimed to support development of a clinical pathway for the management of falls in the community through virtual ward service provision.

The pathway outlines clinical considerations within an episode of care- broken down into immediate point of assessment, ongoing intervention/ actions and transition of

[1] Montero-Odasso et al 2022World guidelines for falls prevention and management for older adults: a global initiative - PubMed (nih.gov)
[2] National Virtual Wards Network. Definitions of virtual ward. Virtual Ward Definitions and Reporting v1 - Virtual Wards Network - FutureNHS Collaboration Platform

care from virtual ward. We acknowledge that this may not cover all eventualities but rather should act as a guide to support when to step some up to virtual ward care under frailty management and when to consider step down to community services.

This document should be used in conjunction with remote monitoring resource guides where available that can support falls management. The identified aspects of remote monitoring detailed in this document is not an exhaustive list but rather a guide to some technology to consider.

This document should be considered alongside the Frailty Virtual Ward (Hospital at Home for those living with frailty)[3] We strongly recommend this document is read in conjunction with the NICE Falls Guidance (CG161)

Workforce Requirements

We recognise that to run different pathways within a virtual ward, services will need to employ a core team of health and social care professionals with skills and capabilities to work across different clinical pathways. When considering the skills and capabilities required to support the management of falls within a virtual ward and the acuity level this may bring, we have detailed the workforce requirements to support this pathway. Access to these professionals is crucial to ensure swift timely decision making that is evidence based, safe, effective and person centred.

We recognise that within the virtual ward pathways utilisation of existing workforce will be optimised. All workforce should have completed the Tier 2b frailty e-learning education programme as a minimum.(Frailty - elearning for healthcare (e-lfh.org.uk)

Variation in level of workforce is dependent upon where the referral route has come from. Some aspects of the care of a person who has fallen may already have been completed by inpatient or community teams . Equally the below are suggestions and we recognise that many workforce are senior decision makers who have varied healthcare backgrounds. ICBs will review the skills and capabilities needed to deliver this pathway and roles may vary.

For clinical management of Falls, the following workforce need to be considered to achieve best outcomes.

[3] NHS England (2021) Frailty virtual ward (Hospital at Home for those living with frailty). B1207-ii-guidance-note-frailty-virtual-ward.pdf (england.nhs.uk)

Multidisciplinary team workforce	Core delivery workforce
Consultant Geriatrician/ GP	Medical expertise in frailty and acute acuity (This could include SpR/Advanced Clinical Practitioners/Physician associate/SHO)
Registered Nurse with experience and competency in rapid response high acuity level decision making.	Registered Nurse with skills and expertise in high level acuity frailty related scenarios.
Registered Occupational therapist and Physiotherapist with skills and expertise in high level acuity frailty related scenarios	Registered Occupational therapist and/or Physiotherapist with skills and expertise in high level acuity frailty related scenarios
Clinical Pharmacist (community)	Health care support workers and rehabilitation support workers or combined hybrid roles.
Older Adults/Frailty social worker	Formal care agency carers
Rapid Response teams	
Care navigators	

Access to: Safeguarding team, Community mental health services, Speech and Language therapy, Dietetics, Podiatry, Memory Assessment Services and any other speciality services as required.

The workforce, regardless of profession should have the skills and capabilities to be able to work with high acuity level care in non-hospital environments, as well a robust understanding of frailty.

This should include capabilities to recognise and work with :

- Acute medical illness
- Bone health
- MSK injury
- Dementia
- Delirium
- Acute phase of rehabilitation
- Fluctuating cognitive state
- Point of care testing
- Medicines prescribing and de-prescribing
- Intravenous interventions i.e. IV fluids, antibiotics, diuretics
- Chronic heart failure management
- End stage COPD
- Bowel and Bladder care inclusive of stoma care
- Swallow difficulties recognition
- Wound care
- Pain management
- End of life care

- Social prescription for care navigation services
- Local services within local catchment and how to refer to them as required

Considerations for hospital admission/Triggers for escalation for patients within the service

Assuming no advance care plan against hospital transfer, patient agreeable to transfer or transfer believed to be in best interest:

Problems uncovered during Virtual ward assessments e.g. Acute medical condition(s) that require ≥24 hours hospital admission
Frailty syndrome that warrants ≥24 hours hospital admission
Injuries that require ≥24 hours of in-patient observations and/or further imaging e.g. intracerebral bleed, spinal injuries where stability is in question
Physiological instability e.g. NEWS 2 greater than 4
Underlying medical illness that can only be managed in acute hospital e.g. Acute MI, Stroke
Severe pain that requires ongoing up titration of analgesia

These triggers are recognised as something that may occur at any point during a person's episode of care and are not isolated to any one stage of the care.

Criteria for accepting onto the virtual ward falls pathway for people living with frailty

Inclusion	Exclusion
Falls in patients aged ≥ 65 without Injuries OR with Injuries that Do Not Require Surgical Intervention or have completed surgical intervention	Major trauma (note that for people with frailty, this can arise as a result of low impact trauma)
Living with Frailty	Immediate or potentially life threatening or limb threatening presentations
Interventions that would have traditionally be delivered in hospital inpatient settings	Head injury with acute confusion and/ or headache and/ or new seizures

Clinical discretion where concerns are present and clinician would otherwise admit to inpatient i.e. head injury in older adult with multi morbidity and risk of slow bleed.	Condition(s) that require time critical investigations and treatments e.g. myocardial infarction, stroke, sepsis, acute abdomen, gastro-intestinal bleeding
Consents to management under Virtual Ward pathway	NEWS2 aggregate score >4 OR any individual parameter with score of 3 that is not their usual 'norm'
	Suspected spinal fractures
	Suspected lower limb fractures requiring surgical intervention and not yet completed.
	Safety netting for e.g.
	Level of care that would traditionally be delivered by community services
	Declines to be managed under Virtual Ward Pathway and chooses to be admitted to hospital instead

Falls Pathway

The pathway is split into four stages to cover the episode of care:

- Immediate actions/assessment
- Immediate interventions
- Ongoing actions and interventions
- Transition back or handover to community interventions

Immediate actions/assessment

Cause of fall	Impact of fall	Holistic care

• History of fall (inclusive of any witness history if appropriate and required) and a focus on symptoms of transient loss of consciousness
• Clinical Frailty Scale (CFS) and Cognitive assessment- 4AT
• PMHx and Drug History
• NEWS2 score
• Lying and Standing BP
• 3 minute stand
• Basic bedside vision assessment,
• Unexplained falls e.g. 'I must have tripped,I don't know what happened'
  ○ ECG
  ○ Bloods and BM
  ○ Urine- MSU
	• Basic examination and check for injury
	• Pain
	• Bruising and swelling
	• Impact of long lie and pressure care
	• Wound care
	• Dehydration
		• Assessment of gait and balance (60 second sit to stand, TUAG, 5 step balance scale or Berg Balance scale) and muscle strength
		• Fracture Risk assessment .e.g. FRAX
		• Full medication review to ascertain what can be stopped and what additional medicines maybe needed for s econdary prevention
		• Assessment of basic activities of daily living
		• Identification of new support needs following the fall
		• Check for advance care plan and lasting power of attorney
		• Check for a universal care plan
		• Review of use of mobility aid needs and pendant alarm
		• Informal care support/ family review

Immediate interventions

Cause of fall	Impact of fall	Holistic Care
Point of care testing Abnormal 4AT commence VW delirium pathway in tandem Strength and Balance training exercise prescription Provision of mobility aid if needed	Hydration protocols Pain management Assessment of basic activities of daily living	CGA if CFS above 5 or above Home hazard assessment for immediate modifications/ adaptations/ equipment Edit or create advance care plan as needed Education to patient on falls inclusive of where appropriate backward chaining to rise from floor Social prescription for shopping, short term support/ overnight care, befriending Refer to Social Services for pendant alarm if required

Ongoing actions and interventions

Cause of fall	Impact of Fall	Holistic Care
Medicines review and changes as needed inclusive of Vitamin D meansurement and treatment as needed	Complete multi factorial risk assessment (MFRA) for falls	Education of falls and information sharing in accessible format that meets person's needs
Investigate falls risk behaviours and strategies to modify	Investigate fear of falls and strategies to address	Investigate what other services are open to the person in the community that relate to reasons for fall
Assess for urinary incontinence issues	Address reversible aspects of falls risks sarcopenia, hypotension etc.	Assessment of instrumental activities of daily living
Assess for Malnutrition		
Ongoing monitoring for delirium (refer to delirium pathway for virtual ward if present)		

Transition back or handover to community interventions

Impact of fall	Holistic care
• Integrated care for older people (ICOPE approach) • Review pain • Review changing (improving or deteriorating) care needs • Review medicines required to support discharge off of virtual ward • Refer to community falls management services for ongoing strength and balance training • Make every contact count opportunities- flu vaccines, covid vaccines, hearing screening	Consider the following aspects based on identified needs through episode of care: • Social prescribing for befriending, access to social community engagement. • Social care assessment of need for any additional care needs or new care needs post virtual ward. • Home based rehabilitation or Reablement referral as needed • Carer assessment if required • Advance care planning • Refer for technology support as required such as pendant alarms • Ongoing social care needs as identified through social care assessment • Referral to memory services • Referral to vision or audiology services • Referral for osteoporosis management • Further investigation of cause of falls if unclear at transition point (cardiology/neurology/falls clinic etc.) • Electronic Transition summary back to GP with follow up actions where required. • Referral to community pharmacy via the Discharge Medicines Service (DMS)

Remote Monitoring Technology

It is important to note that remote monitoring does not replace the need for in person face t face interaction where required. It is recognised that there are already many aspects of remote monitoring utilised within virtual wards that will be useful in woring with someone who has fallen. Below are some identified products. This is a not an exhaustive list.

- Telecare- pendant alarms and other technology equipment companies (TEC)
- Falls Sensors/ Movement sensors
- Predictive telemedicine
- BP monitors
- Weight measuring
- BM monitoring technology
- Skype/ face to face remote consultation devices
- Portable hearing loop devices
- Visual communication boards

Appendix:

RCP lying and standing blood pressure guidance