Frailty/falls car
First Month of operation
Aim of the project

HHFT and SCAS aims to reduce the number of ambulance conveyances relating to falls and frailty by 4–6 patients a day by April 2021.

Key aims:

- Provide specialist clinical assessment early on.
- Comprehensive multidisciplinary assessment in a patient’s own environment.
- Structure intervention around ‘Home first’ principle.
- Reduce risk of conveyance to hospital and further deconditioning.
- Integrated team working and optimisation of current community services.
How it works

An Advanced Occupational Therapist attends low level 999 calls with a Specialist Paramedic.

The vehicle is fully kitted to front-line ambulance response car specification and has ‘blue light’ capacity.

The vehicle carries adaptive equipment to support and facilitate therapeutic interventions/assessments.

**Target Patients:**

- 65 years and over
- Fall with no major injury
- Not coping/social concerns
- Unable to weight bear
- Reduced mobility
- New incontinence
- New onset of confusion
From our first month we found:

- Visits take on average 70 minutes depending on needs of patient
- Average response time is 31 minutes
- Average administration time for each patient 34 mins
- Total average time per patient **2 hours 15 minutes**
- Average age of patient's seen is 83 years old.
- Average Rockwood score 6 (Moderately frail – requiring help with all ADLs)
Conveyance/Non-conveyance data

- 55 patients seen during the period 23/11/2020–16/12/2020 (18.5 working days)
- 8 conveyed of those only 4 admitted
- Average time spent in ED, if conveyed = 3.52hrs
- BNHH ALOS <75 for November = 5 days
- Potential bed day saving = £65,414.25
- Potential conveyance cost saving = £12,650
- Total potential cost saving = £78,064.25
Was the Patient Conveyed to ED Yes/No %

*Note: Due an OT developing COVID + we were not able to run the car every day this month *
Onward referrals

- OPMH referral
- Technician referral
- Careline referral
- Referral to minor injuries unit
- DN referral
- Community therapy
- Telemedicine
- Equipment
- POC/Increase POC
- GP referral
- UCR referral
- CRT referral

Graph showing referral types and their frequency.
Operational challenges

- Rehab bed admission process
- Unable to complete direct referrals for social care funded Careline alarms
- Adult social community care very long waiting times to answer calls
- Limited access to community notes system
- Geographical challenges and travel times
- Variable assessment & admin time required
- Potential staff sickness due to COVID (staff resilience)
Moving forward

- Direct referrals to be taken from crew (already started)
- Patient feedback
- Follow up phone calls where possible
- Provide feedback to crews on the outcome of their direct referrals to improve their own development and assessment skills
- Deep dive into admitted data for the month
Crew Feedback:

“I had a really good experience with the frailty car. I phoned the urgent care desk and it was dispatched within about 10 minutes. Really simple process and a really good outcome for the patient. It’s a fantastic service.” Aj (Paramedic)

“I referred a patient to you in Basingstoke who was 97 and was having trouble mobilising. From my end, it was easy enough to refer her to you and UCD (Urgent Care Desk) were happy to help! Thanks!” Chloe (Student Paramedic/AAP)

“I have used the service once and seemed to work well, the Booking process seems to work ok. I feel that crew feedback would benefit all, as in a quick email with what happened to the PT e.g. the car been able to help (and what help you offered) or if you needed to arrange ED. This feedback will help me as a paramedic learn my actions and assessments were correct and builds my knowledge.” Dan (Paramedic)

“I utilised the Falls car and it was a brilliant asset.’ Speaking to you directly instead of going through the urgent care desk would be of benefit to discuss patients and to see if you can add anything to their care. I called for you for a patient that I was concerned for due to altered cognition and had fallen. I could not find out how the patient usually presented, I asked for you guys but then I managed to contact family. When you arrived at scene (very promptly) I knew more about the patient and probably wouldn’t of called you in the first place, however, there was so much you could do and did do for the patient. A great service and I hope it remains available.” Simon Farmer (Clinical Team Educator NH02)
Case study

- 81 year old Polly. Lives with her husband who has dementia
- No POC.
- Fell at approximately 07.30, unable to get off the floor, husband had been trying to help
- Called 111 at 08.49, falls/frailty car at scene 09.06
- Patient assessed by paramedic, no LOC, didn’t hit head, no new injury. Observations stable.
- Patient was assisted off the floor and on to a chair, using the manga Elk.
• Painful left knee following arthroplasty one month ago
• Painful back due to recent wedge fracture.
• Constipated
• Not eaten in two days due to Nausea, no microwave meals in place and microwave not working
• Medication poorly managed
• There had been deterioration since the wedge fracture and knee operation, was completely independent prior.
• Mood starting to deteriorate as not manging ADL.
• Cognitively intact.
• Fall from bed as too high (23”)
• Unable to get bottom on bed safely
• Unable to complete stairs doing on bottom.
• Unable to attend to PADLS
• Mobile approx. 10 meters independently with WZF but limited by pain
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<th>Problem</th>
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| Recurrent falls – falls identified as due to bed being too high | • Falls assessment completed (SPLATT)  
• Pendant alarm arranged through Argenti  
• Single bed of 20” high ordered from SCRATCH for downstairs and son collected that day. |
| Poor medication management                  | • Paramedic liaised with GP who changed pain medication from liquid morphine to MST and prescribed Movicol.  
• Nomad arranged and delivered the next day to support with compliance & management of medication. |
| Difficulty attending to care needs          | • TDS care started that night through CRT for support with PADLS, medication prompting and meals.  
• Son ordered new microwave and agreed to get microwave meals when completing shopping. Son also agreed to arranging a cleaner. |
| Poor management of medical conditions       | • Follow up telephoned call completed and onward referral to UCR to monitor pain management, bowels and nausea.  
• Checked on EPR and patient had two appointments; one with Rheumatology and one with orthopaedics. Patient was unaware of these; OT advised son who was happy to assist patient to appoints. |