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Supplementary Material for

Efficiency gains from a standardised approach to older people presenting to the emergency department after a fall

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FIONA STANLEY HOSPITAL

FALLS PATHWAY

WARD _____

DOCTOR _____

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

Falls are a major cause of death, injury, functional decline, hospital admission, psychological trauma and institutionalisation in older people. This pathway aims to support older people who present to ED by providing timely assessment of falls risk.

INCLUSION CRITERIA

- Aged 65 years or older
- Fall with 48 hours of presentation
- Has unintentionally come to land on ground or lower surface, **includes medical causes of a fall such as syncope, but not events such as being pushed over**

EXCLUSION CRITERIA

- ATS 1&2
- Suspected #NOF
- Suspected stroke or seizure causing fall
- Conscious state post fall is different to baseline
- Cervical spine precautions in place

STEP 1: If nil exclusion criteria **Triage to Falls stream**

STEP 2: Liaise with ESSU nursing lead (27636) on bed availability of 51 and 53 or high visible beds (Max 2 Falls patients in the **assessment phase** at one time). If nil beds in ESSU send to available bed space in main department and COMMENCE FALLS PATHWAY with paperwork. If isolation required – Bed 50.

STEP 3 (Medical/Nursing): EBM slip under emergency consultant of the day, diagnosis fall

STEP 4: Total ADD score within ATS time frame and completed by ESSU Lead

1 Nursing – ED Risk Screen

The **ED Risk screen** is a tool that identifies baseline functional impairment in vulnerable adults in the Emergency Department. The screen is to be completed on all **falls patients**.

The Risk is positive with the presence or suspicion of 2 or more of the following factors.

	Yes	No
▶ Cognitive Impairment	☐	☐
▶ Five or more medications	☐	☐
▶ Difficulty walking/transferring, or recent falls in the last 6 months	☐	☐
▶ ED use in the last 30 days or hospitalisation in the last 3 months	☐	☐
▶ Lives alone or no caregiver available	☐	☐
▶ ED staff concerns (e.g. primary carer of children/spouse, depression, incontinence, inadequate social support, substance abuse, neglect/abuse, nutritional issues, home environment, ability to manage self-care on discharge)	☐	☐

If positive risk screen
In-hours (8:00am- 07:00pm): Refer to allied health prior to discharge

After hours discharge (07:00pm-08:00am): See Flow Chart. If mobility safe, E-referral via Emergency Medicine Allied Health tab for follow up post discharge.

If unsafe and concerns, ESSU overnight for AH review AM.

Please remember:

- ☐ Postural BP's
- ☐ Urine
- ☐ ECG
- ☐ BSL
- ☐ Low low bed
- ☐ Nursing BOSSNET if admission to ACE

NAME		DESIGNATION	
SIGNATURE		DATE	

2 Medical – 4AT

[1] ALERTNESS
This includes patients who may be markedly drowsy. Observe the patient, if asleep attempt to wake with speech or gentle touch. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for < 10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4
Age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

[3] ATTENTION
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) and arising over the last 2 weeks and still evident in last 24hrs.

No	0
Yes	4

Score 0: delirium or severe cognitive impairment unlikely (but delirium still possible if information incomplete
Score 1-3, and no prior diagnosis of impairment and for discharge refer to GP and suggest memory clinic review
Score 4 or above remain in ESSU or admit for further assessment or refer to ACE

4AT SCORE

Please remember:

- ☐ Bloods
- ☐ Medications charted
- ☐ Imaging as indicated (e.g. head CT)
- ☐ BOSSnet medical admission

3 Medical Officer / Pharmacist

i.) Use this checklist to identify medications that may be associated with an increased falls risk.
ii) List any changes/recommendations in table below.

(In majority of cases the medication review is to prompt recommendations back to patients usual GP)

Medications associated with falls	**i.) Patients medications**	**ii.) Changes/ Recommendations** (discontinued, safer alternative, dose decreased, dose timing optimal, duplication)
Anithypertensives		
Benzodiazepines/sedatives		
Opioids		
Anticholinergic agents		
Psychoactive medications (antipsychotics, antidepressants)		
Insulin/other hypoglycaemic agents		
Other Medications of concern		
Medications associated with increased morbidity and falls	**Patients medications**	**Changes/ Recommendations**
Antiplatelet medication		
Anticoagulants		

iii.) Is the patient on Vitamin D supplementation? ☐ Yes ☐ No
iv.) Is the patient on Calcium supplementation? ☐ Yes ☐ No
→ If **No** to one or both questions refer to GP for patient eligibility

NAME		DESIGNATION	
SIGNATURE		DATE	

4 Allied Health / Nursing Mobility Assessment and Functional Considerations

[1] Lying to sitting (ensure bed flat, rails down and appropriate heigh)

- ☐ Independent
- ☐ Supervision
- ☐ Standby assistance
- ☐ Physical assistance required x1 ☐ or x2 ☐ assist

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[2] Sitting to lying

- ☐ Independent
- ☐ Supervision
- ☐ Standby assistance
- ☐ Physical assistance required x1 ☐ or x2 ☐ assist

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[3] Sit to stand

- ☐ Independent
- ☐ Supervision
- ☐ Standby assistance
- ☐ Physical assistance required x1 ☐ or x2 ☐ assist

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[4] Ambulation +/- walking aid as per baseline distance and baseline walking aid

Walking aids used: _____ **Distance:** _____

- ☐ Independent
- ☐ Supervision
- ☐ Standby assistance
- ☐ Physical assistance required x1 ☐ or x2 ☐ assist

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[5] Functional Consideration

Does the patient require assistance with self-care due to an injury e.g. limb immobilised with cast or sling?
☐ Yes ☐ No

Does the patient have stairs at home? ☐ Yes ☐ No
If Yes, has this been assessed in ED? ☐ Yes ☐ No

****Please use the After Hours Discharge Flowchart to assist in deciding appropriate discharge plan after review completed as above.****

NAME		DESIGNATION	
SIGNATURE		DATE	

DEFINITIONS

Independent

- Patient does not need assistance to perform task, and may use an aid that is usual for them but no physical assistance required

Supervision

- Independent with weight-bearing (either with or without baseline aid e.g. walking aid, bed rail)
- Patient requires constant watching but not necessarily someone to stand in arms reach

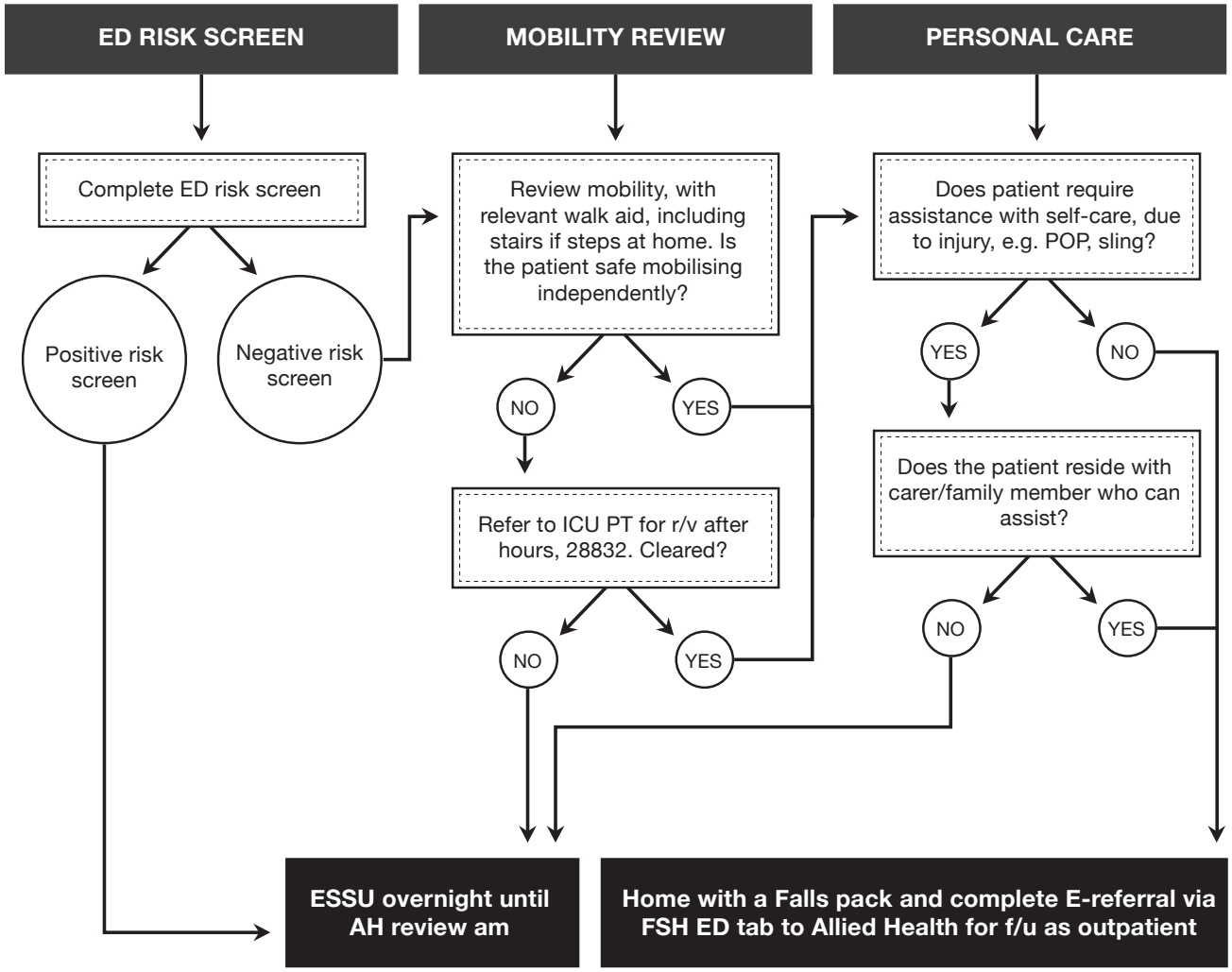
Standby Assist

- Independent with weight-bearing, with or without an aid
- Good ability to follow instructions
- Patient requires staff member to be within arm's reach of patient for safety but not requiring hands on assistance

Physical Assist

- May need some assistance to allow competent weight bearing
- Often becomes unsteady

Falls Pathway After Hours Discharge Flowchart



Patients for ACE (Acute Care of the Elderly) admission from ED-Short Stay Unit (SSU)

ACE ADMISSION

Inclusion

- Falls*
- Delirium
- Dementia**
- Parkinson's Disease
- Colle's #s, Pelvic pubic rami #s, Stable spinal #s for conservative management
- Nursing Home

Refer to:
FALLS Geriatrician
0800 - 1200, M - F
or On call Geriatrician outside these times

Exclusion

- Acutely unwell needing 24 hour medical inpatient care
- Acute surgical problem
- Patients admitted to other specialists
- Delirium/BPSD due to drug or alcohol use or traumatic brain injury
- Fractures,
  Lower limb #s,
  Unstable pelvic #s
  Humerus #s ⇒ **Refer to Orthopaedics**

Legend:

* Falls – patient does not require cardiac monitoring
** Excludes patients with Younger Onset Dementia (YOD)
BPSD – Behavioral and Psychological Symptoms of Dementia

ACE CRITERIA

- Age > 65 years
- Patients who are complex and frail with increased risk of functional decline

Admission checklist

- ☐ BOSSnet notes
- ☐ 6 hour plan
- ☐ Regular meds charted

Falls ED Reg: (as per roster)

0800 - 1200hrs: **FALLS Geriatrician**
Mon - Fri

Weekdays after 1200hrs/Weekends/PH – On call Geriatrician