Supplementary Material for

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

Glenn Arendts\textsuperscript{1,2,5} MBBS, MMed, PhD, FACEM, Associate Professor

Naomi Leyte\textsuperscript{2} BN, Associate Nurse Unit Manager

Sandra Dumas\textsuperscript{2} BScPh(Phys), Senior Physiotherapist

Shabana Ahamed\textsuperscript{3} MBBS, FRACP, Geriatrician

Vethanjaly Khokulan\textsuperscript{3} MBBS, FRACP, Geriatrician

Ouday Wahbi\textsuperscript{2} MBBS, Emergency Medicine Trainee

Andrea Lomman\textsuperscript{4} BScOT, Senior Policy Officer

David Hughes\textsuperscript{3} BN, Nurse Unit Manager

Vanessa Clayden\textsuperscript{2} MBBS, FACEM, Head of Service

Bhaskar Mandal\textsuperscript{3} MBBS, FRACP, Head of Service

\textsuperscript{1}Emergency Medicine, University of Western Australia, Level 2 R Block, QEII Medical Centre, Nedlands, WA 6009, Australia.

\textsuperscript{2}Department of Emergency Medicine, Fiona Stanley Hospital, 102–118 Murdoch Drive, Murdoch, WA 6150, Australia. Email: Naomi.Leyte@health.wa.gov.au; Sandra.Dumas@health.wa.gov.au; Ouday.Wahbi@health.wa.gov.au; vanessa.clayden@health.wa.gov.au

\textsuperscript{3}Department of Geriatric Medicine, Fiona Stanley Hospital, 102–118 Murdoch Drive, Murdoch, WA 6150, Australia. Email: Shabana.Ahamed@health.wa.gov.au; Vethanjaly.Khokulan@health.wa.gov.au; David.Hughes@health.wa.gov.au; Bhaskar.Mandal@health.wa.gov.au

\textsuperscript{4}Department of Health, Western Australia. Level 1, B Block, 189 Royal Street, East Perth, WA 6004, Australia. Email: Andrea.Lomman@health.wa.gov.au

\textsuperscript{5}Corresponding author. Email: glenn.arendts@uwa.edu.au
FIONA STANLEY HOSPITAL
FALLS PATHWAY
WARD __________________________
DOCTOR ________________________

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

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**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.

<table>
<thead>
<tr>
<th>Cognitive Impairment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five or more medications</td>
<td></td>
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<tr>
<td>Difficulty walking/transferring, or recent falls in the last 6 months</td>
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<tr>
<td>ED use in the last 30 days or hospitalisation in the last 3 months</td>
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<tr>
<td>Lives alone or no caregiver available</td>
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<tr>
<td>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)</td>
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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.

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Please remember:
- Postural BP’s
- Urine
- ECG
- BSL
- Low low bed
- Nursing BOSSNET if admission to ACE

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<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION</th>
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<tr>
<td>SIGNATURE</td>
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</table>
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/unknowable 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
Unknowable (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

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)

<table>
<thead>
<tr>
<th>Medications associated with falls</th>
<th>i.) Patients medications</th>
<th>ii.) Changes/ Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anithypertensives</td>
<td></td>
<td></td>
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<tr>
<td>Benzodiazepines/sedatives</td>
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<td></td>
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<td>Opioids</td>
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<td>Anticholinergic agents</td>
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<tr>
<td>Psychoactive medications</td>
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<td></td>
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<tr>
<td>Insulin/other hypoglycaemic agents</td>
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<tr>
<td>Other Medications of concern</td>
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<td></td>
</tr>
<tr>
<td>Medications associated with increased morbidity and falls</td>
<td>Patients medications</td>
<td>Changes/ Recommendations</td>
</tr>
<tr>
<td>Antiplatelet medication</td>
<td></td>
<td></td>
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<tr>
<td>Anticoagulants</td>
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</tbody>
</table>

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 

SIGNATURE 

DESIGNATION 

DATE
### Allied Health / Nursing Mobility Assessment and Functional Considerations

1. **Lying to sitting (ensure bed flat, rails down and appropriate height)**
   - □ Independent
   - □ Supervision
   - □ Standby assistance
   - □ Physical assistance required x1 □ or x2 □ assist

2. **Sitting to lying**
   - □ Independent
   - □ Supervision
   - □ Standby assistance
   - □ Physical assistance required x1 □ or x2 □ assist

3. **Sit to stand**
   - □ Independent
   - □ Supervision
   - □ Standby assistance
   - □ Physical assistance required x1 □ or x2 □ assist

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

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.**

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### 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

**ED RISK SCREEN**
- Complete ED risk screen

**MOBILITY REVIEW**
- Review mobility, with relevant walk aid, including stairs if steps at home. Is the patient safe mobilising independently?
  - NO
  - YES

**PERSONAL CARE**
- Does patient require assistance with self-care, due to injury, e.g. POP, sling?
  - NO
  - YES

- Does the patient reside with carer/family member who can assist?
  - NO
  - YES

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

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

**ACE ADMISSION**
- **Inclusion**
  - Falls*
  - Delirium
  - Parkinson’s Disease
  - Colle’s #s, Pelvic pubic rami #s, Stable spinal #s for conservative management
  - Nursing Home

- **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

**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