North Wales Community Dweller Prevention & Management Pathway

1. Presents for medical attention because of a fall e.g. to GP, ED

2. Opportunistic identification of risk in people aged 65+, using Falls Risk Assessment Tool (FRAT)

3. Basic medical assessment

   - Syncope
   - No symptoms of Syncope

4a. Locality Falls Service (Multidisciplinary Team) – FRAT Triage

   - FRAT score 3+ (Higher Risk)

4b. Locality Falls Service – Multifactorial Risk Assessment (MRA) and Interventions

5. Clinical/specialist investigations e.g. falls & syncope clinic, ENT, continence, audiology, cardiology

   - Appropriate clinical management

6. Community based services/opportunities which promote Healthy Ageing, falls prevention, and maintenance of gains

Discharge from Acute Pathway
1. Presents with a Fall

Definition of a fall:

“An unintentional change in position causing an individual to land at a lower level on an object, the floor or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force” (Tinetti et al 1997, cited in Feder et al 2000)

- Treat any injury due to a fall before an individual enters the falls pathway
- Treat any acute medical condition before an individual enters the falls pathway
- Consider engagement with carers
- GP notified

2. Assessment identifying the level of risk of falls

Older people in contact with health and social care professionals should be asked routinely whenever assessed or as part of the Unified Assessment Process, whether they have fallen in the past year and asked about the frequency and characteristics of the fall/s. (NICE Clinical practice guideline for the assessment and prevention of falls in older people, 2004)

Falls Risk Assessment Tool: (Nandy et al, 2005)

1. Is there a history of any fall in the previous year?
2. Is the person on four or medications daily?
3. Does the person have a diagnosis of Parkinson’s disease or history of Stroke/TIA?
4. Does the person report any problems with their balance?
5. Is the person unable to rise from a chair of knee height?

3. Basic Medical Assessment

- Take Falls History (see box on P6)
- Check Gait and Balance (see box below or P6)
- Consider Osteoporosis Risk (QOF) (see box on P7)
- Medication review (P8)

Medical Problem/Unexplained Fall

Reports of:

- Loss of consciousness
- Suspected blackouts, unexplained falls, dizziness

Go straight to Focused Medical Assessment either in Primary or Secondary Care (the setting for this and the professionals contributing to it depend on local guidelines)

If indicated, the Multifactorial assessment can proceed alongside this assessment.

Recurrent falls/ Single injurious fall/ Single fall with abnormal gait and balance

Individuals who report:

- Recurrent falls (e.g., 2 in last 6 months)
- Single fall with gait/balance problems
- Single fall with injury

Should go straight to a Multifactorial assessment performed by healthcare professionals with appropriate skills and experience.

Single Explained Fall

If presenting with a single explained fall (e.g. clear slip on ice) with stable gait and balance, give Health and Wellbeing advice and review in 6-12 months.
3. Basic Medical Assessment continued

For those who have suspected or confirmed blackouts, and those with unexplained falls, vertigo and dizziness

History from patient and witness

- Past Medical History including history of epilepsy, Ischaemic heart disease, heart failure, diseases associated with autonomic neuropathy
- History of falls and blackouts
  - Frequency, circumstances and situation, description from witness
  - Prodromal symptoms — light headed, dizziness, palpitations, chest pain
  - Post-event weakness, disorientation
- Medication review (P8)
- Look for BPPV

Examination

- AMTS
- Pulse rate and rhythm
- Lying and standing blood pressure
- Auscultate for aortic stenosis
- Sensory and motor neurological assessment
- Assess gait
- Anxiety/Depression

Basic Tests

U&E, FBC, Calcium, 12 lead ECG as clinically indicated

- Measuring postural drop
- Lie patient flat for 5-10 minutes then take BP
- Stand patient and take immediate BP, observe for postural sway and dizziness and record BP after 3 minutes of standing and symptoms. Observe for drop of Systolic BP by 20mmHg, and or diastolic by 10mmHg.

4a. Locality Falls Service (Single Point of Access)

- Multidisciplinary team representing the virtual ‘Locality Falls Service’
- Part of Locality Single Point of Access
- Accepts, records and triages FRATs (falls database)
- Same team as in 4b

4b. Multifactorial Risk Assessment (MRA) & Interventions

Represented by service in box 4a. This should be performed by a healthcare professional with appropriate skills and experience, normally within the setting of a specialised falls service (NICE Clinical Guidelines 21, 2004).

The assessment may include the following:

- Detailed falls history
- Footwear examination/foot check
- Fear of falling
- Review alcohol intake
- Assessment for exercise intervention
- Assessment for Telecare
- Identification of the need of assessment of:
  - Assessment of gait, posture, balance, joint range of movement, and muscle strength
  - Assessment of the person’s perceived functional ability
  - Assessment of visual impairment
  - Assessment of hearing
  - Assessment of cognitive impairment
  - Assessment of bladder & bowel dysfunction
  - Assessment of home hazards
  - Medication review
  - Nutrition/hydration

GP notified of plan & interventions (Reducing Harm from Falls: 1000livesplus.wales.nhs.uk)

See pages 6-8 of this document for MRA details

6. Community based services and opportunities which promote Health Ageing, falls prevention, and maintenance of gains

To who? People aged 65+ (or younger adults at risk of falling)

By? All sector service providers who work with older people

What? Give general advice and provide referral information to:

- Local services which promote health, wellbeing and social inclusion for older people, such as local Ageing Well/Active Ageing centres, volunteering opportunities, lifelong learning, leisure services
- Opportunity for brief intervention relating to alcohol awareness, smoking cessation, healthy eating and drinking, physical activity, mental health and wellbeing (5 ways to wellbeing), immunisations (flu)
- Falls prevention specific information, general foot care, hearing and sight loss, polypharmacy, home safety, exercise targeting balance and coordination

*This requires further work to identify what local information is available on services, and how to refer to them. An information pack will be developed to inform this section in more detail.
5. Clinical/Specialist Investigations

- Bladder and bowel dysfunction (see All Wales bladder and bowel care pathway)
- Postural symptoms (see pathway)
- Confirmed or suspected loss of consciousness including drop attacks
- Vertigo, suspected BPVV, or other ENT problems
- Neuromuscular disorder
- No specific cause found

- Long ECG recording
- Tilt table test
- Consider implantable loop recorder
- Carotid sinus massage

- Cardioinhibition or significant bradycardia
- Vasodepressor response
- Significant dysrhythmia
- No abnormality found

- Management guideline
- Management guideline
- Treat or refer to Cardiology
- Reassess and investigate further
5. Clinical/Specialist investigations

Postural symptoms

Postural hypotension confirmed

- Complete medication review and take action
- Dehydration and hypovolaemia
  - Management including medication review
- Electrolyte abnormality or suspicion of Addison’s disease
- Suspected autonomic dysfunction
  - Refer for autonomic testing

Postural hypotension not confirmed

- Repeat lying and standing BP measurement
- Reassess and consider tilt table test

Pathway to be constructed or Arrange a short synacthen test
4b. Multifactorial Risk Assessment (MRA)

**Detailed Falls History**
- Activity at the time of fall: What happened, when, how?
- Witness, anyone see you fall
- Frequency of falls
- Ability to get up from the floor unassisted (unassisted, not requiring help from another person)
- How many falls in the past twelve months
- Injuries sustained
- Changes to lifestyle as a result of falling, e.g. loss of confidence, not going out alone, now uses walking aid, not getting to the bath etc.
- What footwear was worn at the time of fall

**Fear of Falling**
**Ask**
- Are you frightened of falling?
- What frightens you? (e.g. lying there all night, fractures)

**Assess**
- Ability to summon help
- Ability to prepare for a long time

**Use appropriate assessment tool**
- FES Fear of falling – falls efficacy scale (Tinetti, 1986)
- FES-I (Yardley, 2001)
- ConfBal (Simpson, 1998)

**Recommendation**
- Teach strategies to get up from floor
- Provide info re: summoning help
- Teach coping strategies to prepare for long lie
- Consider:
  - Referral for stress and anxiety management
  - Referral to mental health services

**Assessment of gait, balance, joint range of movement and muscle strength**
Assess gait, balance, joint range of movement and muscle strength.
Assessment tools may include:
- Timed ‘get up and go’ test
- 180 degree turn
- Berg Balance test
- Performance Orientated Mobility Assessment
- Four-square step test

Check use of and/or provide appropriate mobility aids

Guidelines for the Physiotherapy management of older people at risk of falling. AGILE: Chartered Physiotherapist working Older People 2012.

**Functional ability**
- Subjective questioning of ability to manage personal and domestic activities of daily living

Choose appropriate treatment.

**Recommendation**
- Refer for Neurological Assessment
- Refer for Rehabilitation Programme
- Provide appropriate mobility aids
- Refer for Environmental or Home Hazard assessment
- Refer to Social Services or Home care

**Assessment of Hearing**
- Check if any hearing problems
- Check hearing aid working/batteries fitted and working
- Ensure correct use of hearing aid
- Advise about having hearing tested and corrected

**Recommendation**
- Advise to see Audiology department if problems with hearing aids
- Advise to see GP if query hearing loss and not a hearing aid problem

**Assessment of bladder and bowel dysfunction**
- Is there urgency of micturition?
- Is there frequency of micturition i.e. more than 8 voids (day), 2 voids (night)
- Does s/he have a urinary tract infection?
- Does s/he have urge incontinence?
- Is the person taking diuretics?
- Is the person drinking enough fluids i.e. (Approximately 1.5-2 litres)
- Is s/he drinking too much caffeine in drinks e.g. tea/coffee, cola
- Does s/he have problems at night?
- Does s/he have access to commode at night?
- Is s/he wearing appropriate aids?
- Does s/he have mobility problems that make it difficult getting to/n the toilet/commode?

**Recommendation**
Commence All Wales Bladder & Bower Care Pathway. If continence problems persist refer for specialist continence assessment.
### 4b. Multifactorial Risk Assessment (MRA)

#### Assessment of Visual Impairment
- Has there been any change in vision?
- Has the individual visited Optician during the last 12 months?
- Is the individual wearing their glasses and are they clean?
- Do NOT wear bifocals/varifocals to walk around in (e.g. specs for walking around in should be single vision distance spectacles)

**Recommendation**
- Visit the Optometrist annually if there is a history of
  - Diabetes
  - Glaucoma or immediate family member with Glaucoma
  - Early cataracts that need monitoring
  - Over 70 years of age
- Visit Optometrist every 2 years if no problems

#### Assessment of Home Hazards
- Poor lighting, particularly on stairs
- Stairs
- Loose carpets or rugs
- Trailing bed clothes
- Slippery floors
- Need for safety equipment such as grab rails
- Poor heating
- Trailing wires
- Cluttered rooms
- Pets
- Outdoor environment: Steps without rails, loose paving etc.

**Recommendation**
Identify need and refer for Equipment, Aids and adaptations and minor repairs

#### Assessment of Cognitive Impairment
- ACE – Addenbrooke Cognitive Examination
- HADS – Hospital Anxiety and Depression scale

**Recommendation**
Refer according to local guidelines to Mental Health Services

#### Medication Review
- Recent change in medication
- Compliance/ability to take medication
- Taking drugs that may increase the risk of falls:
  - Benzodiazepines & sleeping tablets*
  - Psychiatric drugs Antidepressants Sedating Antihistamines Anticholinergic drugs Drugs for dizziness & nausea Analgesics / Opiates Drugs for Parkinson’s disease* Anticonvulsants Hypertension drugs Cardiac / Angina medication*
  *Refer to appropriate specialist services/nurses/community pharmacist

*This list is not exhaustive*

**Recommendation**
Any change to medication must be followed up

#### Assessment for Telecare
- Lives alone or time left on their own at home
- Fear of falling
- History of alls
- History of long lie
- Previous history Welsh Ambulance Service Trust (WAST)/Response service call out following a fall

**Recommendation**
Refer to local telecare provider

#### Osteoporosis Risk
- History of fragility fractures (any fracture caused by a fall from a standing height)
- Taking long term corticosteroids
- Parental hip fracture
- Body mass index less than 19 & loss of height (>5cm)
- Medical conditions independently associated with bone loss, such as rheumatoid arthritis
- FRAX Tool – Assess risk using on-line tool

**Recommendation**
Refer to North Wales Osteoporosis Pathway
4b. Multifactorial Risk Assessment (MRA)

Exercise Intervention
Effective programmes to include the following components:

- Gait, balance, coordination and function training
- Strength Training and three dimensional activities – dance or tai chi
- Balance training is sufficiently dynamic and challenging
- Exercise programmes to reduce falls should be high dose (>50 hours over 6 months)
- Hospital Rehabilitation Group: 1x week for 2 hours (exercise, education, support, tea and socialise) for 8 weeks. Aim to improve postural stability and the performance of everyday functional activities. Core goal to mobilise out-doors. Supplemented by OTAGO Home-based Exercises which should be individually tailored for each patient. (FaME & OTAGO).*
- Falls “prehab” Preventative Exercise Group held in a community setting (Leisure Centre, church hall, day care centre) 1x weekly for 1 hour for 32 weeks.*
- Specialised exercise group for older people. Exit classes designed for the above population to continue on the exercise pathway. 1-2 weekly in the community setting continuously.

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Nutrition/Hydration
Nutrition
Nutritional Screening to identify if at risk of malnutrition/ or nutritional support if required. Ask if:
- Difficulties with eating e.g. badly fitting dentures/swallowing issues
- Difficulties with handling meals/drinks e.g. arthritic condition, visually impaired
- Problems with digestion/absorption e.g. constipation/diarrhoea
- Reduced appetite/intake
- Special dietary needs e.g. gluten/dairy free
- Unintentional weight loss (3kg/12 months)

Nutritional Screening Tools may be used: either a local one or Malnutrition Universal Screening Tool (MUST) devised by BAPEN

Recommendation
If no dietary problem/s identified:
No dietary intervention required but explain importance of
- A well balanced diet for good health and well being
- Calcium, vitamin D, sunlight for bone health

If problems identified:
Refer as appropriate to
- Dietetic Services for full nutritional assessment, intervention, monitoring
- Therapy/Dental services for physical problems with dysphagia
- Social Services: for help with meal provision where there is limited support for cooking and feeding, and the ability to do this is impaired; delivery services; lunch clubs for social situation. Medical/Pharmacy to adjust prescribed medications if reduces appetite
- CPN/Psychological service for mental health/psychological

Hydration
- Signs of thirst, sunken eyes, loss of strength
- Dry skin (loss of turgor)
- Dry mouth/clarity of speech (which may be affected)
- Dizziness on sitting or standing
- Decrease in urine output, confusion, constipation
- UTI
- Vomiting/diarrhoea
- Fever
- Recent changes/additions of diuretics

Recommendations. A minimum of 8 glasses of 250mls daily will improve these symptoms and postural hypotension, however amount of fluid is dependent on weight and age.

Review Alcohol Intake
Determine units of alcohol consumed per week

Recommendation
- Advise about risks of taking alcohol with medications
- Give sensible drinking advice
- Advise about immediate and long term risk of falling due to dulling of neurological capacity from alcohol

General Foot care examination/check
- General foot health: Diabetic neuropathy, corns/calluses, biomechanical changes
- Footwear suitability scale

Recommendation
- Provide information regarding suitable shoes
- Refer if appropriate to orthotist and podiatrist