Falls in the Community - Initial Assessment in Older People - Full Clinical Guideline

Reference No: CG-GERI/2018/001

1. Summary

This is a practical guideline for assessing and treating older people who present with falls to the medical assessment unit. (MAU). This guideline is separate to the guideline for management of inpatient falls. This guideline is compliant with NICE Guidance.

2. Introduction

Falls are the second commonest cause of admission to MAU. Some falls result in serious injury, which may be not be obvious without careful assessment, and delay in diagnosis may adversely affect outcome.
If a fall is a result of underlying acute illness this should be the initial focus of treatment.
Proper assessment reduces risk of loss of confidence and independence, and may avoid unnecessary or prolonged admission.

3. Aim and purpose

To offer guidance for all clinical staff treating older adults in medical assessment unit at Royal Derby Hospital.

4. Definitions

Fall: A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.[1]

Older people are those aged 65 and over living in their own home, or in an extended care setting such as a nursing home or supported accommodation.[1]

Recurrent falls: 2 more falls within a time period of 1 year.[1]

Multifactorial falls risk assessment: An assessment with multiple components that aims to identify a person's risk factors for falling. This assessment should be performed by a healthcare professional with appropriate skills and experience.[1]

FEAT team: Frail elderly assessment team. A non-ward based team of health professionals including physiotherapists and occupational therapists who assess patients identified as being at risk of frailty in the emergency department, medical assessment unit and short stay wards.

Clinical assessment:

This should include a careful history including current and previous falls, review of medication, thorough examination and appropriate investigations.

The initial assessment should focus on

1. Careful assessment for injuries
2. Check for underlying acute illness as a cause of fall
3. Assessment for orthostatic hypotension and syncope
4. Assessment for underlying causes and contributors to falls, including review of all medication
5. Be aware that falls are usually MULTIFACTORIAL and require an MDT approach to assessment and treatment

1. Assessment for injuries

Look for injuries carefully. Falls from <2m are the commonest cause of traumatic death in patients over the age of 75 in the UK. Impaired postural righting reflexes, reduced muscle or soft tissue bulk and osteoporosis may lead to significant fractures and potentially life threatening injuries in falls from standing height. Look actively for occult injuries, and beware of diagnostic pitfalls including:

- Pain and injury may lead to delirium, and a history of injury may not be given.
- Consider head injury as a cause for any confusion, especially in anticoagulated patients
- Injuries may have occurred with recent falls before the current one.
- Masking effect of distracting injuries, eg. pain from a humeral or clavicle fracture masking fractured ribs

Cervical -spine injuries are often missed. NICE guidelines suggest CT C-spine is the imaging modality of choice in the >65 year old group if indicated. Immobilisation is not required (see ED cervical spine assessment guidelines Cervical Spine - Clinical Guidelines - Derby) and collars are contraindicated in this age group.

Low impact trauma rib fractures can occur in the elderly and are easily missed. Have a high index of suspicion in elderly patients with upper extremity injuries, chest pain or respiratory symptoms. Carefully examine the chest wall for tenderness or bruising. Consider haemo-thorax as a cause of pleural fluid or lung contusion as a cause for consolidation on CXR. Rib fractures may be easily missed on CXR. If high index of suspicion for rib fractures, review with a senior Dr regarding CT scanning. In cases with rib fracture, follow the trust guideline on management of blunt chest trauma. (Chest Wall Trauma (Blunt) - Clinical Guidelines - Derby) Patients with pain from acute rib fractures require referral to the surgical registrar, and medical wards will often not be appropriate for initial admission. Required interventions may include referral to SAU or Step down unit, and critical care outreach team.

A systematic examination should include check for bruising of hips/pelvis, and pain and range of motion of hips. X–ray pelvis/hips if concerned.

Check for neck and head injury and Use NICE clinical guideline 176 “head injury in adults” to decide whether to do a CT scan of the head. www.nice.org.uk/guidance/cg176

It is the policy in Royal Derby Hospital that all elderly trauma patients seen in ED are reviewed by a Consultant in ED so that they have a proper primary and secondary survey for injuries, including whole body CT when indicated.

2. Assessment for acute illness

A 'fall' in an older person can occur because of an acute illness, eg pneumonia or acute coronary syndrome. This will be usually be obvious after a history, examination and initial tests. Delirium is a common cause of falls and the trust guidelines should be followed.(Delirium - Clinical Guidelines - Derby)

Bacteruria can be a normal finding in old age, especially in women, and will manifest with leucocytes and nitrites in the urine. Do not diagnose a UTI in an older person based on a urine dipstick or culture alone, in absence of symptoms or fever

3. Assessment for postural hypotension and syncope.

Review medication. Diuretics, anti-hypertensives, alpha blockers and antidepressants are common causes of orthostatic hypotension. Check lying and standing BP. If there is a drop of > 20 mmHg systolic, medication may need to be modified/stopped. Look for biochemical evidence of dehydration. 'Unexplained' falls in which people 'just go down' – especially those with a normal gait and balance – could be syncope. Check for cardiac murmurs, especially aortic stenosis, and ECG abnormalities and consider investigation for syncope in these cases. Follow the Trust guideline on syncope where applicable. (Syncope/Presyncope - Investigation in Older Patients - Clinical Guidelines - Derby)

4. Assessment for underlying causes and contributors to falls

A basic falls assessment should be performed by the first doctor or advanced nurse practitioner to see the patient. **Falls in older people are rarely accidents ('mechanical'), but are usually due to medical problems (eg poor vision, abnormal gait and balance, medication).** The purpose of the basic falls assessment is to identify these problems. In studies, patients attending Emergency Departments because of a fall have an average of five reasons for falling.

Assess for:

Cognition: Enquire about memory problems, and carry out a full AMT

Continence: Enquire about incontinence/urgency/nocturia.

Medication history: Apart from medication contributing to orthostatic hypotension, consider medications with potential for sedative, cholinergic or extrapyramidal side-effects eg opiates, benzodiazepines, antidepressants, antipsychotics.

Vision: check for poor vision (eg. undiagnosed cataracts) and bifocal use. Active older people who wear bifocals or vari-focals are more likely to fall and should be advised to wear plain spectacles when walking about. Referral to optician or ophthalmology clinic may be required for some patients with visual impairment.

Neurological examination: Look particularly for signs of weakness, peripheral neuropathy and parkinsonism.

Musculoskeletal assessment: Check for significant arthritis, especially fixed flexion deformities.

Timed get-up-and-go test. (if patient able): Ask the patient to rise from a chair, walk 3 metres, turn around and return to the chair. A person with normal gait and balance can complete this within 10 seconds. This may be undertaken by the assessing doctor or FEAT team.

Further assessment:

Elderly patients who have fallen, and may be discharged from ED, MAU or Short stay wards should be assessed by the FEAT team, as part of their multifactorial falls risk assessment. FEAT will carry out comprehensive assessment including enquiring regarding home/environmental hazards, and may recommend interventions including mobility aids, social services support and referral to the falls clinic for patients with a history of recurrent falls.

Patients admitted to base wards to be assessed by the ward based therapy team.

Patients with known or suspected Parkinsonism **must** be referred to the Parkinson's team.

Refer known cases to Parkinson's Nurse specialist, suspected new cases to neurology or DME consultants with special interest.

Admission

If there is no acute illness and no significant injury then patients may not need to be admitted to hospital following a fall. Patients who have had FEAT assessment and have appropriate support in the community can be discharged.

Short stay admission may be required in patients who are seen overnight and cannot be safely discharged

Older people with a serious injury should be admitted to hospital, with an appropriate ward determined by a senior clinician depending on the injury.

Patients with an acute illness causing falls should be managed in the medical ward of an appropriate specialty or short stay/general medicine team.

Principles of further management:

Multifactorial and Multidisciplinary approach to assessment and management

Thorough holistic assessment

Treat injuries and acute medical problems appropriately as per trust guidelines

Appropriate assessment and management of syncope/orthostatic hypotension

Review medication.

Assessment and management of falls risks.

Prior to discharge from hospital, consider risk of osteoporosis and fracture risk in all patients with falls, and investigate and treat accordingly.

See NICE guideline: Osteoporosis: assessing the risk of fragility fracture. Clinical guideline [CG146] Published date: August 2012. (link)

Consulting the trust guidelines for Syncope, Osteoporosis, management of injuries and medical conditions (including Delirium) will be helpful where applicable.

Onward referral to outpatient clinics including Falls and ENT should be considered on discharge.

References:

1: NICE guidance: Falls in older people: Quality standard [QS86] Published date: March 2015

Guideline development group:

Documentation Controls

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