

FALLS

*Prevention Management
Programme*

A & E Falls Programme

PROTOCOL FOR A&E W.G.H.

Definition of a Fall.

'Unintentionally coming to the ground or some lower level and other than as a consequence of sustaining a violent blow, loss of consciousness, sudden onset of paralysis, as in a stroke or an epileptic seizure.'

Referral Criteria

- Patients must be over 65 years of age
- Patient arriving at A & E following a fall – as defined above
- Medical examination has taken place by doctor and patient must be medically stable
- Patients will be seen in A & E department, MAU, Ward, home or residential home.
- If it arises that there are no falls admissions, it will be under the discretion of the therapist to assess and advise on other conditions if felt appropriate and refer to other agencies as appropriate.

What will the Falls Programme Service provide?

Multifactorial falls risk assessment:

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness within A & E department
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear related to falling
- Assessment of cognitive impairment
- Social assessment
- Environmental Risk assessment

Multifactorial intervention:

- Provision of mobility equipment and environmental adaptations
- Liaison with other agencies to provide care if required
- Facilitate Safe, appropriate and timely discharge from A&E

- Post A & E discharge check at home as appropriate and establishing individually tailored rehabilitation programme aimed at preventing future falls.
- Onward referral to appropriate services for longer term rehabilitation if required e.g. intermediate care, community falls programme, falls programme in the day hospital and relevant community therapy teams
- Educating fallers about preventive measures
- Professional education

Referral Procedure

1. Complete Referral forms and follow the written instructions at the foot of the form to identify where to place the form
2. Therapists will review the daily print out and identify patients appropriate for phone screening. "Fall" must appear on the print out.

STANDARDS OF PRACTISE

Referral

1. All patients fit into referral criteria
2. All referrals must be in writing on Falls Programme referral form or from computer printout
3. Referral will be collected once a day
4. Referrals ideally should be completed as early in the day as possible, in order to assess needs of clients and conduct a risk assessment, including provision of care and equipment
5. If referrals are found inappropriate, the therapist will liaise with the key nurse in A & E
6. Prioritisation of referrals will take place by therapist, in liaison with key nurse, if required
7. If a client is discharged before the referral is collected, a therapist will assess at home after discharge

Monitoring Falls Patients

- All patients who have fallen are recorded on computer in A & E – the therapist will take a copy each day
- All patients seen in A & E who have fallen will be monitored
- A daily list will be obtained from A & E admission
- Each patient will be contacted by telephone if not admitted
- Each patient who is admitted will be followed up on the ward

Assessment

1. All patients having been referred from A & E will have an assessment by a therapist in A & E

2. A therapist or assistant will collect social history from key nurse, next of kin, carers
3. If appropriate, a home assessment will be conducted by a therapist with the patient from A & E (see home assessment policy)
4. Equipment will be provided if appropriate to ensure safe discharge. It will be assessed for and provided by therapists
5. Care needs of the clients will be addressed in A & E and also during the home assessment and care provision will be made to ensure safe discharge
6. Clients with a care package paid for by Social Services:
 - If care package to be re-started at existing level, this can be reinstated by therapist, liaison with social worker - contact social worker
 - If a client had a care package paid for by S.S. but care needs have changed, contact Maureen Cole on 5174. If care cannot be provided, liaise with Intermediate Care
 - If client does not have an existing care package, contact Intermediate Care.
7. Clients admitted to MAU or Wards following a fall, the Falls Therapist will liaise with the ward, re: risk assessment/discharge planning/home visits and implementation of the Falls Prevention & Management Programme

FOLLOW ON THERAPY/DISCHARGE

1. Following a successful home assessment, the patient will be left at home, A & E will be notified.
2. If the patient would be at risk if left at home, the patient will return to A & E for admission.
3. If the patient is assessed to be at risk if left at home, but the patient refuses to return to hospital, a disclaimer form must be signed by the patient. A copy to go to therapy notes, original in medical notes. Therapists will endeavour to reduce any risks as far as it is reasonably practicable.
4. A Falls Programme leaflet will be issued to all patients following assessment with a follow-up appointment.
5. Following discharge home, a post-discharge assessment will be made by a therapist or generic assistant. During this assessment, any continuing therapy needs will be discussed with the patient and carers. Appropriate referrals will be made to Intermediate Care, TOPS Therapy, Community Physiotherapy or Falls Prevention & Management Programme.
6. Outcome summary of therapy intervention will be sent to the G.P. and other appropriate services.

EVALUATION

1. On completion of A & E intervention and post discharge visit, an evaluation form will be completed for data input
2. A weekly meeting will be held by all therapists working in A & E to discuss the current service and development needs

3. Therapists, social workers and managers will hold a monthly operational meeting

HOME ASSESSMENT POLICY

1. If patient is to accompany therapist for a home assessment, two members of staff must be present in the care. A relative/friend could not be the second person, but may travel in the same car if necessary.
2. Patients must consent to home assessment.
3. Patients must be medically fit to travel and left at home following assessment.
4. Following an A & E assessment, if a patient is seen to have complex needs and may require extra care and equipment, it is advised that a home assessment will not take place after 3 p.m. (This is at the discretion of the therapist)
5. Before a home assessment takes place, access to the property will be discussed. If it is felt that the patient might not manage access, e.g. flight of steps, ambulance transport will be sought. Therapists will liaise directly with ambulance desk to ensure transport within times of working.
6. Prior to a home assessment, the therapist will liaise with social worker and Intermediate Care in order to ascertain availability services
7. If the patient is taken ill during a home assessment: if near to hospital return immediately or telephone 999

EVALUATION DATA TO BE CORRELATED

1. Number of referrals. Number of inappropriate referrals.
2. Response time.
3. Number of falls admitted to wards. Of those admitted:-
 - Number with fractures
 - Other trauma/medical
4. Length of stay in hospital
5. Number of clients left at home following home assessments.
 - Number of clients returned to A & E
 - Number of clients who signed disclaimer
6. Re-admission rate – liaise with A & E
 - Number of re-admissions Ward intervention
 - Reason for re-admission
7. Number of hip protectors provided
8. Follow on therapy - Telephone check

TOPS	In-patient – Orthopaedic
Intermediate Care/Therapy	Community Physiotherapy
Day Hospital	Day Centre
Falls Prevention & Management Programme – Part II	
Community Occupational Therapy	Other
Social Services	
9. Intervention - number of visits

A & E

Barthel
Confidence
TUSS
180°
EMS
BP

On post-discharge assessment

Barthel
Confidence
TUSS
180°
EMS
MTS

- 10. Continuing Falls Prevention & Management Programme Statistics.**
- 11. Travel – collect petrol receipts and sent to Oakridge Office (monthly)**