

FALLS RISK ASSESSMENT

MODULE: CORE MEDICINE: CARE OF THE ELDERLY

TARGET: F1/2 & CT1/2

BACKGROUND:

Falls are common in older people and can result in considerable morbidity.

- About 30% of people 65 years of age or older have a fall each year, increasing to 50% in people 80 years of age or older
- The risk of falling is multi-factorial, and prevention is usually based on assessing multiple risk factors
- About 5% of falls in older people who live in the community result in a fracture or hospitalization.
- Between 10% and 25% of falls in nursing homes and hospitals result in a fracture.
- The incidence of hip fractures in the UK is 86,000 per year, and 95% of these are the result of a fall. The cost to the NHS is £1.7 billion a year [National Collaborating Centre for Nursing and Supportive Care, 2004].

RELEVANT AREAS OF THE CMT CURRICULUM

Core Medicine R.3. Falls in the Elderly	
Knowledge	Recall causes of falls and risk factors for falls
	Knowledge of what's involved in the assessment of a patient with a fall and give a differential diagnosis
	Recall the relationship between falls risk and fractures
Skills	Recall consequences of falls, such as loss of confidence
	Define the significance of a fall depending on circumstances, and whether recurrent, to distinguish when further investigation is necessary
	Identify awareness of implications of falls and secondary complications of falls
	Commence appropriate treatment including pain relief
Behaviour	Recognise the psychological impact to an older person and their carer after a fall
	Contribute to the patients understanding as to the reason for their fall
	Discuss with seniors promptly and appropriately
	Relate the possible reasons for the fall and the management plan to patient and carers
	Recognise advice provided by national guidelines on head injury (e.g. NICE)

INFORMATION FOR FACULTY

LEARNING OBJECTIVES

Assessment of the patient at risk of falls

Management of patients with a falls risk

SCENE SETTING

Location:	Outpatient Clinic	Expected duration of debriefing:	40	mins
Expected duration of scenario:	20	mins		

EQUIPMENT AND CONSUMABLES

Set of patient notes
 List of medications
 GP referral letter
 Dina-Map obs machine
 Tendon hammer
 Result of postural blood pressure
 Result of urine dip
 Patient gown
 Falls Risk Assessment Tool (FRAT)

PERSONNEL-IN-SCENARIO

Patient actor
 CT1/2
 Clinic nurse (faculty)

PARTICIPANT BRIEFING

You are the medical SHO in the rapid access elderly care clinic, and your next patient is Mrs Greta Anderton, a 73 year old woman who has been referred by her GP after having fallen at home.

See attached GP Letter:

Dr Flannigan, Dr Bedford & Dr Benson



*West Park Healthcare Centre
Oxford
OX4 6BD
Tel: 01865 729549*

Dear Doctor,

Re: Greta Anderton
DOB: 14/10/39

Many thanks for seeing this delightful 73-year-old lady, who has been troubled by an increasing frequency of falls at home. She was previously independent, however has become somewhat socially isolated over the last few months because of the falls. She fell again this afternoon, and I am concerned about the frequency of falls, as she is at home alone.

Her past medical history includes hypertension, psychotic depression, and osteoarthritis of both knees.

Her current repeat prescription is as follows: Lisinopril, bendrofluzide, doxazosin, prednisolone, mirtazepine, imipramine, solifenacin, nitrazepam, prochlorperazine, warfarin, cocodamol.

Her examination was grossly normal. BP 140/70, HR 85, Sats 97%, Temp 37.0oC.

I am unsure as to the cause of her falls, and would be most grateful for your help with her management.

Yours faithfully,

Dr J Flannigan
MB BS, MRCGP, DRCOG, DCH

FACULTY BRIEFING

'PATIENT ACTOR' BRIEFING

73yo, Greta Anderton, has had increased falls over the last two months with reduced mobility over the last two weeks. She has had approximately 2 falls a week. These occur particularly after standing. They are not preceded by any chest pain or breathlessness or palpitations. Her legs 'just seem to go'. She feels dizzy and unsteady when crossing the room and feels the need to hold on to something. Her GP started prochlorperazine for this which probably hasn't made a difference. She has had some urinary incontinence which didn't improve with several courses of antibiotics so GP started solifenacin (something to help your bladder muscles). She has stopped going out recently because she is afraid of falling. She has fallen again (last week, 4 days ago) and she called the GP who saw her on a home visit, and has then referred her to the rapid access clinic.

The fall itself – happened when she got up out of her chair whilst watching Coronation Street on the TV, to answer the door bell (her daughter was coming over to visit. She did not lose consciousness, but did feel dizzy, and felt that her legs "just seemed to go". She didn't have any chest pain or palpitations. She didn't have any changes to her vision or hearing. She did not hit her head. She fell onto her left knee and left elbow. These are bruised and sore, but not broken (the GP organised for her to have x-rays done at the local minor injuries unit, and they told her so)

PMHx Hypertension, TIA (mini-stroke), DVT (clot in the leg) 2 years ago, PMR (polymyalgia rheumatic – sore arms and legs), Colles' fracture (broke your wrist) 3 years ago, psychotic depression, OA knees (sore knees when you've been up and about for a long while – your GP says its "wear and tear" arthritis)

DHx Lisinopril, bendrofluazide, doxazosin, prednisolone, mirtazepine, imipramine, solifenacin, nitrazepam, prochlorperazine, warfarin, cocodamol (don't worry about remembering them – you will have a list of medications that you can give the participant).

Allergic to amlodipine – ankle swelling, erythromycin – diarrhoea

Social History - Lives alone in a house. Family have bought a frame but she doesn't like to use it. No carers currently but is awaiting OT assessment. Has three children, one son lives abroad, two daughters nearby who are helping out with shopping and cleaning. Has microwaveable meals. Husband died in a nursing home two years ago with subdural haemorrhage after a fall. Was going visiting neighbours frequently until the last few weeks because too scared to leave house.

IN-SCENARIO PERSONNEL BRIEFING

Clinic nurse – you have done the observations, including a postural (lying and standing) blood pressure reading, and have done a urine dipstick tests. You are busy with other patients, but will come in and out of the room every few minutes asking if the participant needs any help, or would like a cup of tea.

ADDITIONAL INFORMATION

On Examination:

CVS: HR 87. BP 168/72 lying, 139/60 standing. Patient is not symptomatic. HS I + II + 0. No oedema. JVP Normal
Resp: Sats 98% on air. Lungs clear.

Abdomen: ?Faecal mass LIF

Cranial nerves: ?Macular degeneration. Otherwise normal. FROEM

Neuro: Slight bradykinesia bilaterally, mild cogwheeling bilaterally. No tremor. Proximal power 4/5.

Difficulty getting out of chair without the use of arms. Timed get up and go test is 22 seconds. Slightly stooped, reduced gait speed, shuffling, increased turn time.

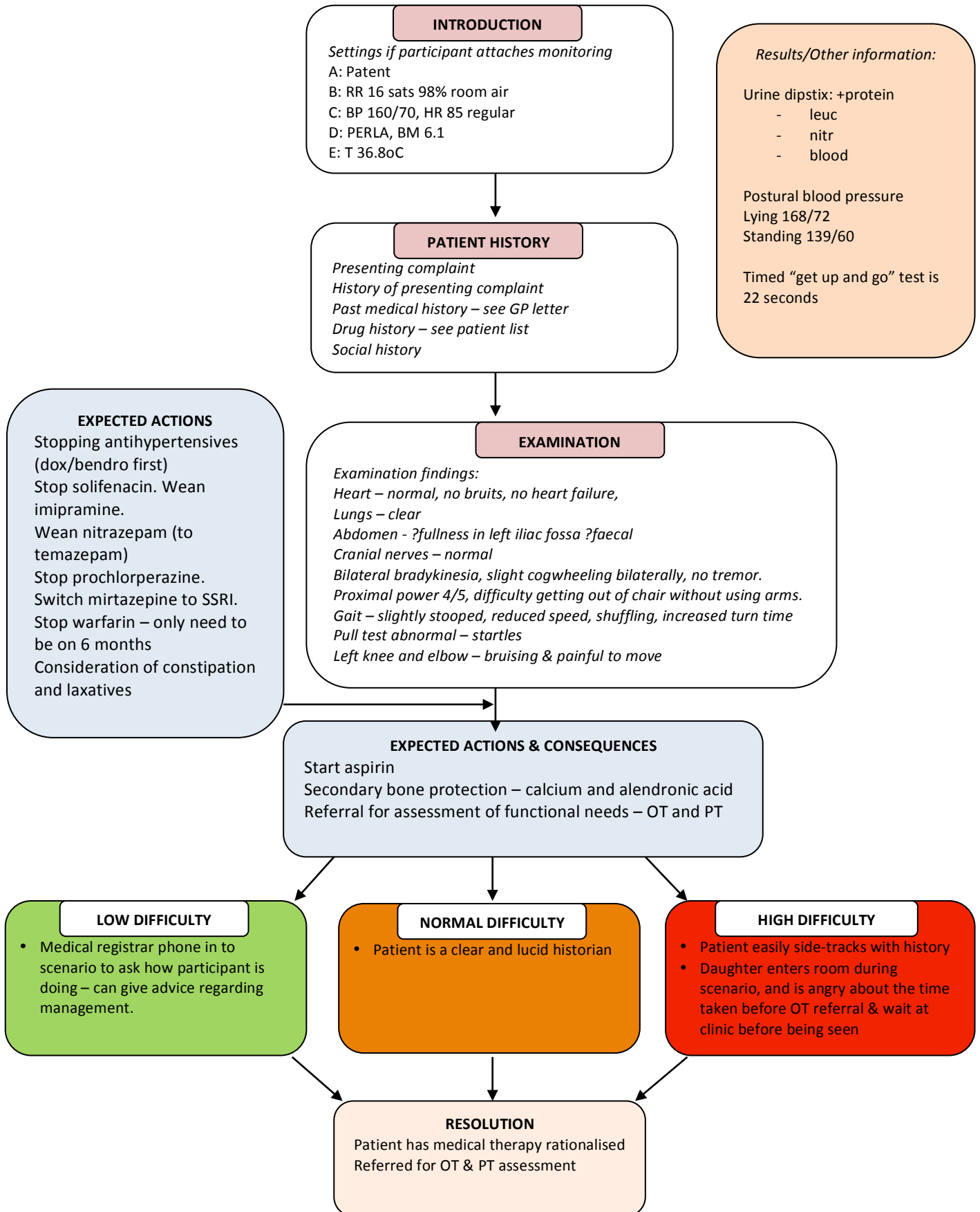
Pull test abnormal – startles.

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Editor: Dr Andrew Darby Smith

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CONDUCT OF SCENARIO



DEBRIEFING

POINTS FOR FURTHER DISCUSSION

- Iatrogenic orthostatic hypotension
- Polypharmacy
- Iatrogenic increased falls risk: anticholinergics, benzodiazepines, opiates, prochlorperazine
- Proximal muscle weakness – PMR, OA, steroids
- Age related instability
- Increased risk of harm from falls: bleeding, fracture
- Psychological impact of falls
- Insufficient social support
- Drug-induced parkinsonism
- Incontinence – accurate diagnosis uncertain

DEBRIEFING RESOURCES

http://www.cks.nhs.uk/falls_risk_assessment

FRAT (falls risk assessment tool)

GERIATRIC MEDICINE > SCENARIO 6

INFORMATION FOR PARTICIPANTS

KEY POINTS

Assessment of the patient at risk of falls

Management of patients with a falls risk

RELEVANCE TO THE CURRICULUM

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FURTHER RESOURCES

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PARTICIPANT REFLECTION

What have you learned from this experience? (Please try and list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?

PARTICIPANT FEEDBACK

Date of training session:.....

Profession and grade:.....

What role(s) did you play in the scenario? (Please tick)

Primary/Initial Participant	<input type="checkbox"/>
Secondary Participant (e.g. 'Call for Help' responder)	<input type="checkbox"/>
Other health care professional (e.g. nurse/ODP)	<input type="checkbox"/>
Other role (please specify):	<input type="checkbox"/>
Observer	<input type="checkbox"/>

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I found this scenario useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand more about the scenario subject	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have more confidence to deal with this scenario	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The material covered was relevant to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write down one thing you have learned today, and that you will use in your clinical practice.

How could this scenario be improved for future participants? This is especially important if you have ticked anything in the disagree/strongly disagree box.



FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn't it go well?

How could the scenario be improved for future participants?