Approach to Older Patients with Falls in the Emergency Department (ED)

VGH Grand Rounds

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Kira Gossack-Keenan, R3

* Extremely common presentation in ED
* Older people may be living at risk and having less healthcare follow up due to pandemic
* Complex patients- difficulties in history taking, vague and delayed presentations, underlying comorbidity and polypharmacy
* Have impaired immune and cardiovascular response, decreased peripheral sensation and blood supply, impaired renal function and altered medication metabolism
  + Like “beta blocked immunocompromised 50-year-old”
* Older adults (65+) make up 17.5% of Canada’s population, but 30% of all VGH ED visits
  + Longer stays in ED and higher admission rates
* 1/3 of older adults have at least one fall per year
* Significant cause of morbidity and mortality in this group
* 1/3 seen in ED will have significant functional decline within 3 months, and 1/3 will fall against in 6 months
* Falls risk factors: previous falls, polypharmacy, impaired hearing, eyesight or proprioception, loss of mobility
* Assessment should include head to toe exam, labs (CBC, electrolytes, renal function, medications levels, +/- trop or serum tox screen), ECG, imaging
* Significant falls risk with polypharmacy, especially benzodiazepines, anticholinergics, sedatives
  + Each medication >4 increases risk of fall 14%
* Consider flagging inappropriate meds for de-prescribing by GP or iCare physician
* Term “mechanical” fall inaccurate- implies external mechanical source as cause
  + Rarely true- more likely sign of gait, balance problem, difficulty with vision or proprioception, postural hypotension, polypharmacy or loss of muscle tone
  + Can be falsely reassuring but no difference in rates of revisits, hospitalizations, death, recurrent falls among “mechanical” versus “non-mechanical” groups
  + Consider term “non-syncopal” mechanism fall instead
* Consider atypical presentations leading to fall:
  + Substance use common, but underdiagnosed and undertreated
    - Higher vulnerability to harm from altered metabolism, comorbidities and fragile brain
    - Consider in vague presentations- recurrent falls, delirium, depression, self-care deficits
    - At risk of severe withdrawal- need supervised withdrawal due to risk of delirium, falls, dependency in activities
    - Lorazepam first line as all older patients have degree of prolonged hepatic metabolism
  + Elder abuse- underreported but increasing, usually community dwelling adults experiencing psychological abuse
    - Risk factors: cognitive impairment, female, older age, social isolation, mental health or substance use
    - Consider in head/neck/upper extremity injuries, delay in presentation
    - Need higher level of suspicion
    - Duty to report under Adult Guardianship Act if suspected abuse and patient unable to seek support due to any of: physical restraint or handicap, illness limiting ability to make decisions
  + Depression- underdiagnosed, highest rates completed suicide in this group
    - More likely somatic versus mood complaints (sleep, anxiety, pain)
  + UTIs- asymptomatic bacteruria VERY common (50% of individuals from LTC)
    - Degree of positivity not helpful
    - Associated harm with treatment (12% of LTC residents developed C diff)
    - Get urine for fever or leukocytosis PLUS one: CVA or suprapubic tenderness, gross hematuria, incontinence, urgency, frequency, or change in urine with change in mental status
    - Consider not sending urine- difficult to not treat once resulted
* Falls patterns: lower extremity, trunk/spine and skull/intracranial most common
* Risk assessment: 2+ falls/year or 6+ meds= higher risk falls, consider referral
* Consider frailty score, not all older patients are the same
* Order DAT, off monitors, oral analgesics and mobilization, home meds
* Emphasize on discharge that you’re worried about their fall and encourage follow up
* CML unable to assess over phone the next day- can give patients central access number
* Excellent follow up resources: falls clinic (if no neurologic or movement disorder), geriatrics rapid access, older adults mental health and addictions services

For more learning: geri-em.com (Excellent modules from geri emerg team in Toronto)