ENABLING SAFE MOBILITY IN THE ED

24/7 access to mobility assist devices

Bedside commodes and grab bars in restrooms

Even floor surfaces

Rubber or nonskid floor surfaces/mats

Handrails on walls and hallways

Aisle lighting

EQUIPMENT & DESIGN ELEMENTS TO PREVENT FALLS WITHIN THE ED
FALLEN OLDER ADULT MANAGEMENT (FOAM) PROTOCOL

Note: This is an example - Your protocol may vary

IDENTIFICATION

FALL
• Patient is 65 years or older with report of fall
• Fall detection questions asked
• EMR fall care path opens

ASSESSMENT

No medical or trauma concern

Associated medical concern

Associated trauma

EVALUATION

Medical Evaluation

Trauma Evaluation

INTERVENTION

PROBABLE DISCHARGE
• Uncertain Disposition
• Timed Up & Go (TUG) testing
• PT consults if TUG ≥ 14 seconds
• Orthostatic vital signs
• Transitions of care w/ social worker and/or case manager consults

DISCHARGE
• New path for social work
• Case management transitions of care

TRANSMISSION/ REFERRAL

DISCHARGE

Telephone call-backs

PT referrals as appropriate

PROBABLE ED TO HOSPITAL ADMISSION
• Trauma consult as needed
• Transitions of care started by ED social worker
• In-patient geriatric consult ordered
• In-patient PT consult ordered

ADMISSION
• Geriatric and PT consults
• Social work communication path

Note: This is an example - Your protocol may vary
Post-Fall Assessment in the Emergency Department

1. **ATTENDING MD ASSESSES**
   - Ask yourself: “If this patient was a healthy 20-YO, would he/she have fallen?” If no, then the assessment of the underlying cause of the fall should be more comprehensive.

2. **TAKE A HISTORY THAT INCLUDES:**
   - Location & cause of fall
   - Difficulty with gait and/or balance
   - Falls in the previous (X time)
   - Time spent on the ground
   - Loss of consciousness/AMS
   - Near/syncope/orthostatis
   - Melena
   - Specific comorbidities: dementia, Parkinson’s, stroke, diabetes, hip fracture, depression
   - Visual or neurological impairments such as peripheral neuropathies
   - Alcohol Use
   - Medications
   - Activities of Daily Living
   - Appropriate footwear

3. **MEDICATION ASSESSMENT**
   - Medication assessment should be performed on all patients at risk or who have suffered from a fall. Special attention should be given to those patients currently taking any of the following classes of medications: vasodilators, diuretics, antipsychotics, sedative/hypnotics, and other high-risk medications (see AGS’ BEERS criteria for a full list).

4. **ADDITIONAL ASSESSMENTS**
   - Orthostatic blood pressure assessment
   - Neurological assessment with special attention to presence of neuropathies & proximal motor strength
   - Complete head-to-toe for ALL patients, even those presenting with seemingly isolated injuries
   - Safety assessment prior to discharge to include an evaluation of gait and a “Timed Up and Go Test”. Patients not able to rise from the bed, turn, and steadily ambulate out of the ED should be reassessed.
   - Admission should be considered if patient safety cannot be assured.

5. **DIAGNOSTIC TESTS**
   - Although there is no recommended set of diagnostic tests for the cause of a fall, a threshold should be maintained for obtaining an EKG, complete blood count, standard electrolyte panel, measurable medication levels and appropriate imaging.
TIMED UP & GO TEST

This is a quick and simple test to measure mobility and fall risk for older adults who can walk on their own.

Before you begin, make sure you have measured 3 meters (about 10 feet) and marked that distance with a landmark that the older adult can see. Be sure you have a stopwatch and a standard armchair.

INSTRUCTIONS:

- Begin with the senior sitting in an armchair with hips and back at the back of the seat and arms resting on the arm rests. Make sure the senior is wearing their usual footwear and has any normal assistive device that he/she would typically use.

- Ask the senior to stand up by saying, “When I say ‘go’ I want you to stand up and walk to the line [or insert appropriate landmark], turn, walk back to the chair and then sit down again. Walk at your regular pace.”

- Start timing as you say the word “Go” and stop timing when the senior is seated again.

Expected Gait Speed

<table>
<thead>
<tr>
<th>AGE</th>
<th>DESCRIPTION</th>
<th>RATING</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>Overall</td>
<td>7.9 seconds</td>
<td>0.9</td>
</tr>
<tr>
<td>70-79</td>
<td>Overall</td>
<td>7.7 seconds</td>
<td>2.3</td>
</tr>
<tr>
<td>80-89</td>
<td>Without device</td>
<td>11.0 seconds</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>With device</td>
<td>19.9 seconds</td>
<td>6.4</td>
</tr>
<tr>
<td></td>
<td>Overall</td>
<td>13.6 seconds</td>
<td>5.6</td>
</tr>
<tr>
<td>90-101</td>
<td>Without device</td>
<td>14.7 seconds</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>With device</td>
<td>19.9 seconds</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Overall</td>
<td>17.7 seconds</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Predictive Interpretation

<table>
<thead>
<tr>
<th>SECONDS</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10</td>
<td>Normal, freely mobile</td>
</tr>
<tr>
<td>&lt; 20</td>
<td>Mostly independent, can go out alone</td>
</tr>
<tr>
<td>20-29</td>
<td>Variable mobility, requires assistance</td>
</tr>
<tr>
<td>&gt; 30</td>
<td>Mobility impaired</td>
</tr>
</tbody>
</table>

A score >14 seconds is associated with a higher risk of falls


Shumway-Cook, A., Brauer, S. Woollacott, M. Predicting the probability of falls in community-dwelling older adults using the timed up & go test. Physical Therapy, 2000; 80(9):896-903.
The Role of the Mobility Champion

Mobility champions have:

- A commitment to quality care for older adults
- Leadership experience
- Excellent interpersonal skills
- The ability to influence and engage others in a course of action

It is recommended that each ED has multiple mobility champions, ideally at least one on each shift in the ED in order to fully promote your mobility protocol.

Gaining Administrative Support:

The Mobility Champion should also gain administrative support from the ED and hospital leadership. Administrative leaders have a unique, behind-the-scenes role in establishing and supporting a mobility program in the ED. Administrators will lay the groundwork for staff empowerment and can ensure that the different clinical teams gel in this effort. We recommend approaching a senior member of the hospital management team with decision-making capacity. This individual can help support implementation efforts and provide resources to start and sustain your program.

You will need to convince your administrative leadership that a mobility protocol in the ED is an essential paradigm shift which may require providing additional education or hiring staff. Administrative leaders can help advocate for the change within the hospital decision-making hierarchy and help transmit the importance of the program to other administrative leaders.

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