
Improving healthcare delivery to older patients following an ambulance call out

Implementing an evidence-based approach to prevent falls and reduce frailty

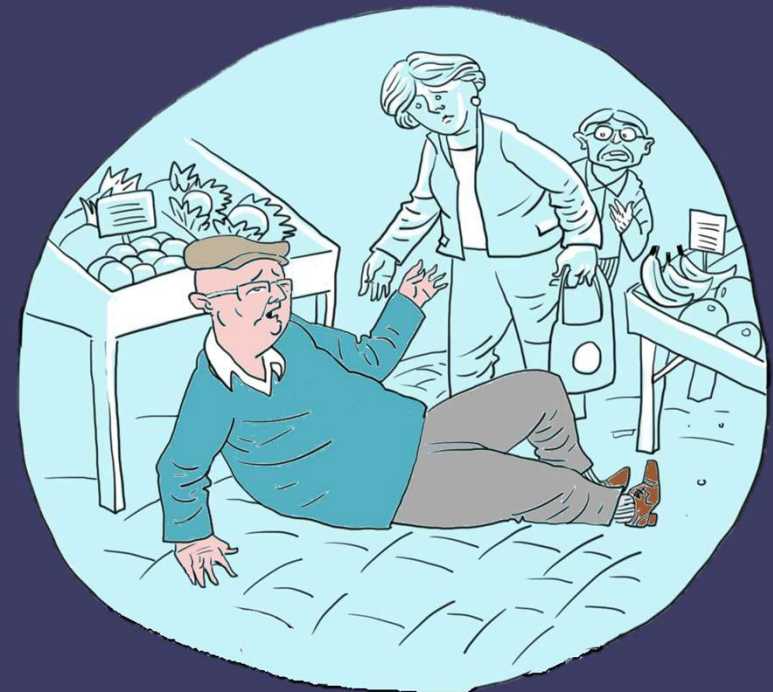
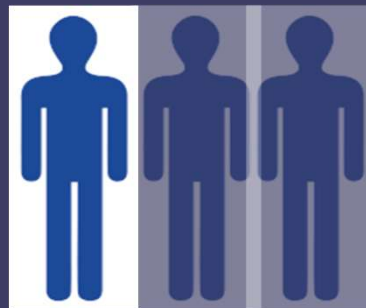
Dr Meghan Ambrens



Frailty and Falls



One in three 65+



22% suffer recurrent falls

Frailty and Falls in New South Wales



Older Persons Protocol

Elder At Risk Screen

FROP-Com Screen

CFS



Falls Risk for Older People in the Community (FROP-Com) Screen		(Affix Patient ID label)								
LR No: _____ Surname: _____ Given name: _____ DOB: _____										
Screen all people 65 years and older (50 years and older Aboriginal and Torres Strait Islander peoples)										
Date of screen: / /										
FALLS HISTORY		SCORE								
1. Number of falls in the past 12 months?	<input type="radio"/> None (0) <input type="radio"/> 1 fall (1) <input type="radio"/> 2 falls (2) <input type="radio"/> 3 or more (3)	()								
FUNCTION: ADL status										
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (e.g., cooking, housework, laundry)? • If no fall in last 12 months, rate current function.	<input type="radio"/> None (completely independent) (0) <input type="radio"/> Supervision (1) <input type="radio"/> Some assistance required (2) <input type="radio"/> Completely dependent (3)	()								
BALANCE										
3. When walking and turning, does the person appear unsteady or at risk of losing their balance? • Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid, observe the person with the aid. Do not base on self-report. • If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3.	<input type="radio"/> No unsteadiness observed (0) <input type="radio"/> Yes, minimally unsteady (1) <input type="radio"/> Yes, moderately unsteady (needs supervision) (2) <input type="radio"/> Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	()								
Total Risk Score ()										
Total Score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0-3 Low risk				4-9 High risk					
Recommended actions	Further assessment and management if functional/balance problems identified (score one or higher)				Perform the Full FROP-Com assessment and/or corresponding management recommendations					
Date: / /										
Name: _____ Signature: _____ Designation: _____										

 1. Very fit People who are robust, active, energetic and motivated. They commonly exercise regularly and are among the fittest for their age.	 6. Moderately frail People need help with all outside activities, housework and cooking. They often need help with stairs and bathing, and might need minimal assistance with dressing.
 2. Well People who have no active disease symptoms but are less fit than category 1. Typically, they exercise or are very active occasionally, such as seasonally.	 7. Severely frail People completely dependent for personal care. However, they seem stable and not at high risk of dying (within ~6 months).
 3. Managing well People whose medical problems are well controlled but are not regularly active beyond routine walking.	 8. Very severely frail People completely dependent and approaching the end of life. Typically, they could not recover even from a minor illness.
 4. Vulnerable While not dependent on others for daily help, often symptoms limit activities. A common complaint is being 'slowed up' and/or being tired during the day.	 9. Terminally ill People approaching the end of life. This category applies to people with a life expectancy of <6 months, who are not otherwise evidently frail.
 5. Mildly frail People often have more evident slowing and need help with high-order IADLs. Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.	<p>IADL = instrumental activity of daily living (such as finances, transport, heavy housework or medications)</p>

Methodology



Lismore

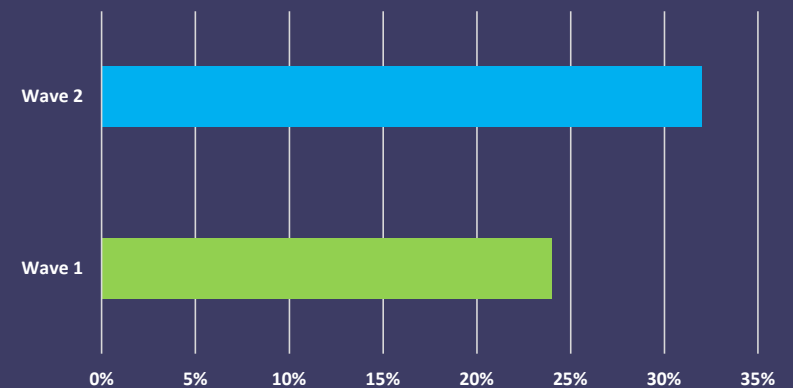
Tweed Heads
Kingscliff
Campsie (metro)

30 (29%) paramedics registered to participate

13 (43%) completed the survey

9 (30%) completed the focus group

Study Engagement



Results: focus group

Effectiveness

- CFS provided greater value and clinical utility than the EAR
- CFS enhanced decision making, meaningful measure of frailty

"I actually found the other score (CFS) much better. You could probably better identify where your patient sits on that sort of larger scale"

- Utility of the CFS was seen to depend on the availability of appropriate referral pathways

Acceptability

"I actually found that CFS app quite useful, because it sort of broke it all down in a, you know, dummy's way of understanding it. I actually really like that"

- Dissatisfaction with the training, including the way it was delivered

"looking at a screen and listening to someone talk for 20 minutes, I'll probably retain about 30-40% of it"

Appropriateness

- CFS reflected patient's true condition and prompted deeper clinical assessment

"I think it gives a more complex analysis of the patient"

- CFS enhanced communication with patients and clinical staff but did not capture social support and services well

"... it doesn't necessarily hit whether or not they're getting access to those supports"

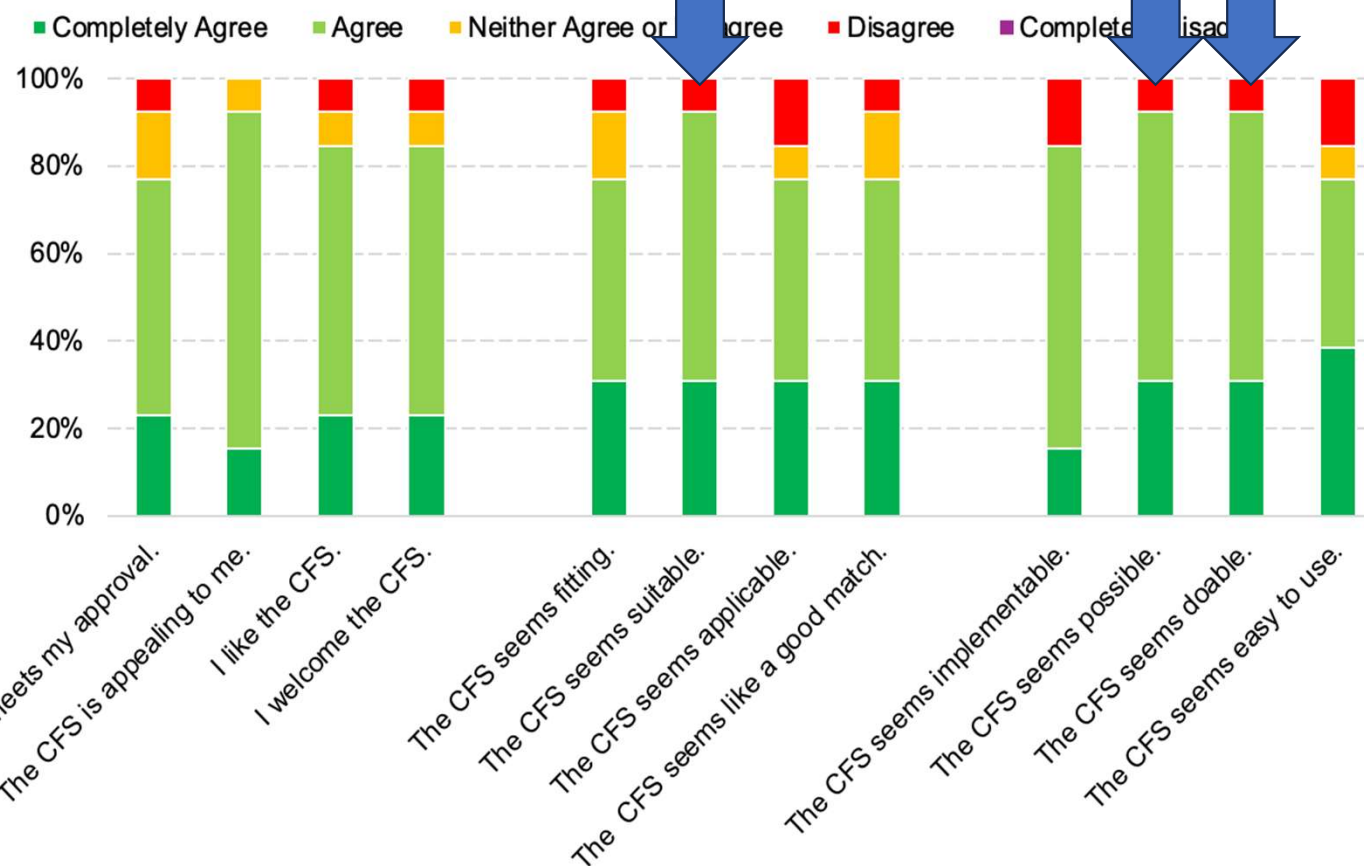
Feasibility

- Combination of CFS & FROP-Com effective in practice

"I think they work well together ... I feel like that's helping me give the patient the best idea of what we're dealing with"

Results: survey

Rating of Acceptability, Appropriateness and Feasibility



- Median (IQR) score of 4 (0.5) for acceptability
- Median (IQR) score of 4 (1) for appropriateness
- Median (IQR) score of 4 (0.5) for feasibility

Results

Current role & System constraints

- Health professionals integrated within the broader health system
“I’m looking at how they were walking, are they doing ok with their wheelie walkers? It’ll also be assessing the house, asking if I can look at their kitchen, asking about how they’re getting their shopping done”
- Paramedics frequently encounter service gaps
“they’re just kind of sitting there in limbo and they don’t know who to contact ... and they could be deteriorating really quickly”
- In the absence of accessible referral pathways, hospital is seen as the default
“I know that if I leave this person at home, I’m going to come back in another half hour and pick them off the floor again.”
- Hospital provides assurances that the patient will receive care
“There’s nothing there for us to refer them into ... so they end up in hospital”
- Contributes to inefficiencies
“In that regard we feed into the problem. Now I’ll sit there on bed-block for a couple of hours”

Results



Barriers to Referral Pathways

- Rural areas face the greatest referral limitations
- After hours service availability is a major concern

“If its not Monday-Friday, 8-4pm, we haven’t got quite as many things that we can refer to”

- Unable to verify whether referral plans were followed or who is responsible

Facilitators of Referral Pathways

- Metropolitan areas have greater access to a range of referral options and benefit from denser healthcare networks

“Well connected in terms of referrals and there’s probably better access to allied health services for people who live in our area just because the population size is dense”

- Relationships built with referral services were described as collaborative and patient-focussed.
“They are super supportive ... They want to work with you to make that decision as safe as possible”

Recommendations for rolling out the CFS



- To improve uptake, training should be integrated into shift schedules and delivered in brief, practical formats
- Linking the CFS scores to actionable referral options would strengthen its clinical utility
- Further work is needed to develop and coordinate clinical pathways, especially in regional settings and after-hours
- Visible leadership and support is important for motivation, as is understanding the CFS's impact on patient outcomes
- Embedding the CFS into the EMR

Conclusion

The CFS, used alongside the FROP-Com is a feasible, acceptable and appropriate tool

Enables structured, evidence-based assessments and supported clinical decision making

Full impact will depend on effective referral pathways, practical training and workflow integration



Investigators



Dr Meghan Ambrens
Associate Professor Paul Simpson
Tom Doyle Byrne
Professor Chris Poulos
Dr Craig Sinclair
Professor Peter Gonski
Dr Kirsten Davis
Claire Walker

Stephanie Looi
Martin Nichols
Professor Cathie Sherrington
Professor Lin Perry
Julia Dayhew
Lillian Miles
Adam Engeler
Professor Kim Delbaere

Questions

