Central Adelaide Local Health Network

Falls Assessment Clinics

Falls assessment clinics provide multi-disciplinary assessment and management for older people with complex falls related presentations. The Geriatrician-lead team consists of an occupational therapist, physiotherapist and nurse. There are 2 Falls Clinics within the CALHN region which include the Sefton Park Clinic and The Queen Elizabeth Clinic.

Eligibility:

Client consents and is willing to adopt strategies and interventions recommended.

- Individuals aged 65 years or older (or 50 years ATSI)
- Multiple co-morbidities
- Is not attending a multidisciplinary program
- Does not have an acute fracture or acute illness (i.e. medically stable)
- History of 2 or more falls in the past 12 months or 1 fall with a serious injury (injury should no longer be acute)
- Living in the CALHN region (community and Low level care)

The role of the clinic is:

- Multi-disciplinary assessment of falls risk factors
- Recommendations to address falls risk factors, communicated to the patient, family member (if appropriate), GP, community health workers, and referrer
- Recommendations re: management of medical issues, medications, evaluation and management of osteoporosis, cognition, mood/psychiatric comorbidities, continence
- Recommendation or referral to appropriate falls and balance program
- Recommendation or referral for occupational therapist home safety assessment if indicated
- Recommendations or referral to appropriate community support, carer support, ACAT assessment, information on personal alarm
- Recommendations on visual assessment, hearing assessment, footwear, podiatry, nutrition
- Follow up (telephone or clinic review)
- Patient and family education on falls
- Education for medical students, allied health students

For more information

Central Community Falls Prevention Service
PO Box 43 Woodville
SA 5011
Telephone 1300 0 FALLS (1300 0 32557)
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Government of South Australia
SA Health

Multi-disciplinary Team

The clinic has a multi-disciplinary model. Each patient is discussed at a case conference at the end of the clinic. The roles of the team are:

Geriatrician/Geriatrics Registrar

- Assess falls risk factors, medical comorbidities, medications, social history
- Detailed falls history including time/date of fall, circumstances, associated symptoms, injuries, treatment, health care intervention
- Screening for osteoporosis
- Cognitive screening with history, mini-mental state examination
- Clinical examination including cardiovascular, neurological, gait examination
- Review of ECG, recent investigations – blood tests, radiology

Nurse

- Assess postural blood pressure, ECG
- Nutrition assessment: measure BMI,
- Medication Management
- Mood assessment: Geriatric Depression Scale
- Continence assessment: History of urinary/bowel symptoms/incontinence

Physiotherapy

- History taking with mobility indoors/outdoors, community, use of gait aids
- Assessment of muscle strength, transfers, gait quality, dizziness, footwear, podiatry input, feet, sensation (LT, JPS), range of motion, exercise tolerance
- Balance assessment: Rombergs, tandem stance, single leg stance, postural sway
- Outcome measures: Timed up and go (TUG), TUG cognitive, sit to stand x5, functional reach

Occupational therapy

- History of living situation, home modifications, equipment, community supports, social supports
- Visual screening: history, ophthalmology/optometry review, use of corrective lenses
- Visual assessment: visual acuity (Snellen) with and without corrective lenses, contrast sensitivity (Melbourne Edge Test), visual fields (to confrontation)
- Hearing assessment: history, audiology input, use of hearing aids
- Assessment of function: Barthel index
- Discussion about personal alarm, advanced directives , respite

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