A new report published by the Royal College of Physicians shows that most local health services are providing inadequate care to older people who have fallen and sustained a fracture (RCP Clinical Effectiveness and Evaluation Unit, 2007; NT News, 13 November, p4).

This is the first national clinical audit to investigate the care received by individual patients who have fallen and sustained a fragility fracture of the hip, wrist, humerus, pelvis or vertebra. It was commissioned by the Healthcare Commission.

The Department of Health has also published best practice guidance outlining urgent care pathways for older people with complex needs, for use in A&E and ambulance services (DH, 2007). This guidance shows how A&E nurses can improve the care of older people presenting with falls, confusional states or hip fracture.

MAIN AUDIT FINDINGS
The RCP report finds that trusts are failing to meet national standards on the care and prevention of falls (RCP Clinical Effectiveness and Evaluation Unit, 2007).

The audit indicators are based on a range of standards, including the National Service Framework for Older People and NICE guidance (NICE, 2005; 2004; DH, 2001). The report says: ‘As judged against these standards, this audit shows an unacceptable degree of variation across the NHS, and that an inadequate service is being provided by most local health services in hospital care and in prevention of future falls and fractures.’

The results from 157 trusts in England, Wales and Northern Ireland included:

- Some 80% of people with hip fractures spent more than two hours in A&E before being transferred to a suitable ward, in contrast to accepted best practice;
- Most patients returning home from A&E after a fragility fracture were not offered a falls risk assessment and only 22% were referred for exercise training to reduce future falls;
- Three months after sustaining the fracture, only one-fifth of these patients were on appropriate treatment for osteoporosis;
- Even after recovering from hip fracture surgery, fewer than 50% of patients were on appropriate osteoporosis treatment;
- In only one in 10 cases did patients’ notes document that they had been given information on how to prevent further falls;
- For the minority of patients who attended a falls clinic, the falls and fracture risk assessments and treatment offered were better. PCTs should consider commissioning specialist services such as falls clinics.

The report makes recommendations for trusts and the DH (see www.rcplondon.ac.uk).

IMPROVING CARE
The DH’s best practice guidance advises on adapting emergency response systems for older people presenting with falls, confusion or hip fracture, through simple screening tools (DH, 2007). It also provides the basis for audit of practice.

The DH acknowledges that an in-depth assessment by frontline staff may be unrealistic, but they can identify at-risk older people and refer them for specialist assessment and care.

The guidance identifies best clinical practice in the three areas of falls, confusional states and hip fracture, and then outlines a care pathway.
Falls
The DH states that older people presenting with falls is a major issue for A&E departments. It points out that there is considerable under-reporting of falls and blackouts in older people because the consequence of the fall (namely, the injury or fracture) becomes the diagnosis, the sole focus of attention and the subsequent code for the episode of care. The DH concludes that over one-third of falls go unreported in computerised A&E records, which in practice results in the wider issue of falls prevention becoming overlooked.

The falls care pathway, as outlined in the NSF and NICE guidance (NICE, 2004; DH, 2001), involves primary prevention (environment and lifestyle issues); case finding of people who have fallen or who are at risk of falling; multidisciplinary assessment for falls risk factors; and an individualised, multi-agency intervention for falls prevention.

The DH points out two aspects that are particularly relevant for A&E – case identification and multifactorial falls risk assessment. A&E staff should consider contributing to case identification and starting (but not undertaking) comprehensive assessment.

Confusional states
Confusional states are another common presentation in older people (DH, 2007). Estimates suggest that 10–30% of older people presenting to A&E have delirium. Terminology is important but not always well understood, according to the DH. It provides definitions of dementia and acute confusion (often referred to as delirium) and adds that the two clinical syndromes can coexist, as dementia is the major risk factor for delirium. Research suggests that delirium is often under-recognised or misdiagnosed as dementia, or simply recorded as ‘a confused elderly patient’ (DH, 2007).

The DH stresses that it is important for A&E staff to improve delirium case finding by routinely incorporating a test of cognitive function for older people presenting for emergency care.

Hip fracture
A hip fracture is the most serious complication of a fall in an older person – it carries a threat to survival and future independence, according to the guidance. Most patients with hip fractures are older people with complex needs.

The DH emphasises that A&E staff should ensure rapid diagnosis and rapid transfer to the orthopaedic trauma ward.

URGENT CARE PATHWAY
The care pathway comprises four audit topics with actions for each one. The first topic, on improving case identification of fallers, states that A&E departments should routinely ask all older people if their attendance is related to a fall or blackout. A positive response should be linked to the final audit topic.

The second topic focuses on improving A&E routine assessment of older people, where hospital admission is being considered. Actions to take are:
- Assessment of gait and balance by observation of standing and walking (using usual walking aids);
- Assessment for confusion using a cognitive impairment instrument.

Failure on either of these two assessments should be linked to the fourth audit topic. The DH adds that as a matter of course patients attending A&E should have temperature, pulse rate and blood pressure recorded. These two assessments above could also be considered routine for older people.

There are many formal assessments for gait and balance, and the DH explains that the ‘Get up and go’ test has been well researched, is quick and simple and suitable for use in A&E (see www.dh.gov.uk). The guidance states there are several methods to assess cognitive function. It recommends the four-point AMT4 (Abbreviated Mental Test) as it is quick to use so suitable for A&E (Swain et al, 2000) (see box).

The aim of the third audit topic is to improve management of hip fracture within A&E. The recommended action is diagnosis and immediate management (X-ray; IV fluids; IV analgesia; subcutaneous heparin; and pressure-relieving mattresses) to be achieved in under four hours of patients’ arrival in A&E.

The final audit topic’s aim is to improve integration of A&E departments with mainstream older people’s services that offer comprehensive assessment.

To achieve this, patients presenting with falls/blackouts and those with impaired gait or confusion should be offered referral for comprehensive specialist assessment.

For details on the suggested audit indicators for this care pathway, see www.dh.gov.uk.

THE AMT4 COGNITIVE FUNCTION TEST

The AMT4 records the responses to the following questions:
- What year are we in?
- What do we call this place you are in?
- How old are you?

- What is your date of birth? An incorrect answer to any of the four questions suggests cognitive impairment may be present.