APRIL FALLS MONTH

2024 JMO Falls Prevention Education

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NSW GOVERNMENT Health
Northern Sydney Local Health District

CLINICAL EXCELLENCE COMMISSION

APRIL FALLS DAY

APRIL FALLS MONTH

Better 'Balance' for Fall Prevention

- April Falls Month® is an annual NSW campaign to raise awareness about the impact of falls
- Did you know:
  - 37% of all injury related deaths are caused by falls?
  - 23% reduction in falls with regular exercise
- The overall campaign goal is to get active and improve overall 'balance' for fall prevention – inclusive of social activity.
- The last year has been a gradual return to normal, however many older adults have been affected, leading to deconditioning, increased frailty, social isolation and increased admissions to hospital
- To prevent falls and maintain independence, the campaign promotes exercise or activities that improve strength and balance.

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APRIL FALLS MONTH

Falls Facts - Community

- In the community 1 in 3 people over the age of 65 will have a fall per year
- This increases to 1 in 2 for people 80+
- The risk of falls is greater for women than men
- 67% fall in the home - 54% in living areas, hallways and the bedroom only 10-12% in bathrooms, kitchens, laundry and toilets. Only 28% in public spaces.
- 50 - 60 % of lower care residents will have a fall per year
- Higher care residents falls rates range from 30 – 60% per yr
- 15% of older people fall within 1 month of discharge from hospital

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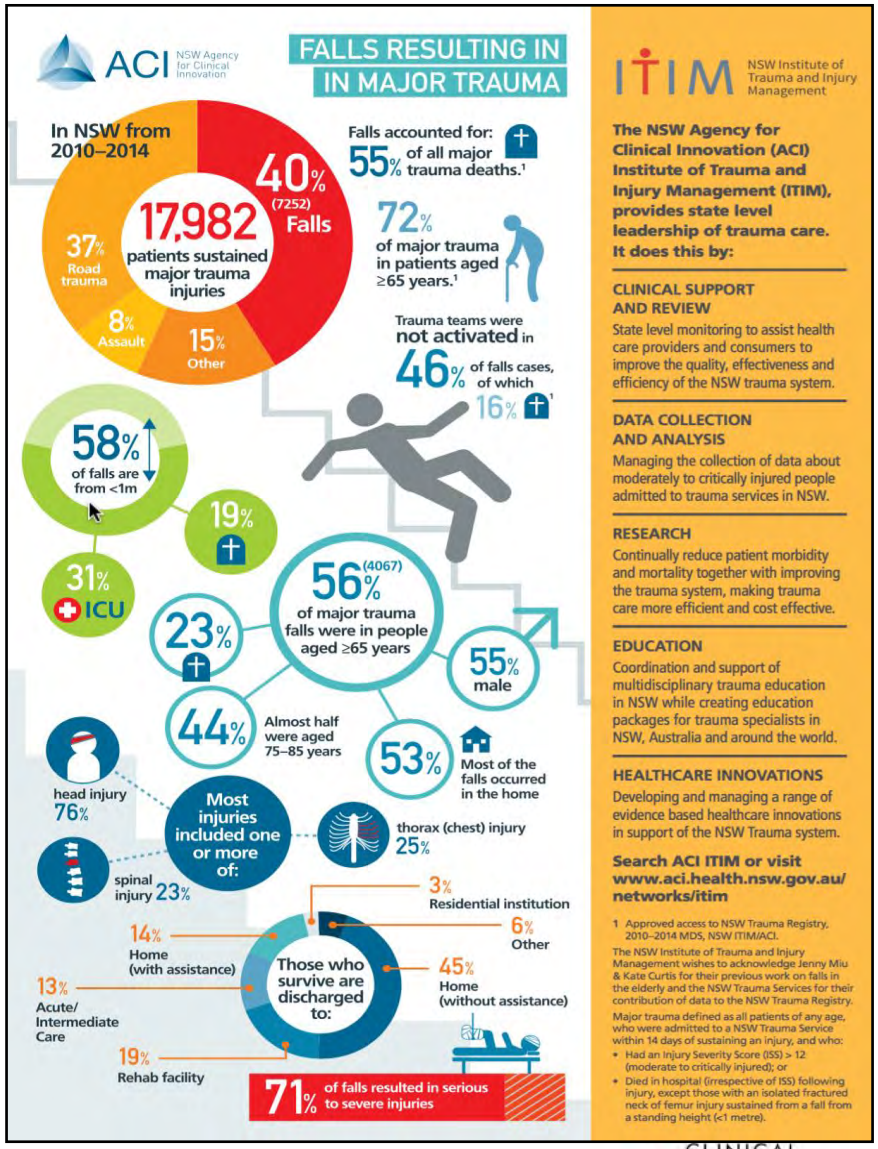
Falls coming into Hospital via Trauma Services NSW

- Falls accounts for 72% of major *trauma* patients aged 65 years and older
- Falls accounted for 55% of *all* major trauma **deaths,** exceeding road trauma.
- 76% head injury
- 55%male
- 53% occurred in the home
- Height of fall: 58% < 1 metre



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What about falls in Hospital?

Who, what, when and where?

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Who falls in hospital?

- 75% of all patient incidents in our hospitals involve a fall
- Falls occur across all ages from neonatal to older adults
- Patients **who are mobile** with **impaired mental status are at the highest risk**

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Where people fall and what are they doing?

- 70% occur around or from the bedside
- 60-80% are un-witnessed
- Falls usually related to **toileting**
- 30-40% will result in a physical injury
- NSLHD is in the top 5 LHDs in NSW with serious falls; death, head injury, fractures.
- These are regarded as a Hospital Acquired Complication (HAC) and are monitored by MoH.

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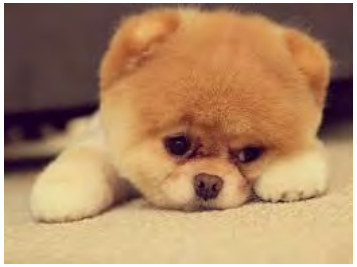
Why are falls an issue?



In-hospital falls are associated with:

- Increased LOS:
- Need for additional investigations and possibly surgery;
- Reduced function and increased fear of falling for the individual;
- Altered discharge plans; and increased use of community services;
- Potential change in living arrangements eg. residential care.
- Increased cost to healthcare system.

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Overview of Hospital Initiatives

Screen all consumers admitted to hospital	→	Screen in ED, pre-admission or on admission to ward within 8 hrs. Use adult/paeds risk screening pathway
Implement standard CARE ACTIONS to prevent falls	→	Use standard safe **CARE ACTIONS** for **all** patients
Falls risk assessment and management planning	→	Complete **Goals of Care (GoC)/FRAMP** for those who score **at risk within 8 hrs** and implement actions
Change in consumer condition/fall	→	Rescreen via RSA and update **GoC /FRAMP'** Follow **Post-fall guides**
Reporting and monitoring	→	Fall incidences & fall injury e.g. IMS+
Discharge planning	→	Communicate risk and plan for follow-up at home

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General Risk Factors for Falls In Hospital

- History of **falls**
- Patient has **cognitive impairment**
- **Post operatively**
- Is on **medications** that increase falls risk
- Needs to go to the **toilet urgently**
- **Unsafe mobility** and **transfers**
- Has **poor vision**, such that everyday function in the ward is impaired
- **Unfamiliar environment**

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Medical Conditions that can cause falls.

- Acute delirium of any cause
- Stroke and other neurological disorders affecting balance and gait
- Metabolic disorders eg diabetes, also in younger MH consumers
- Postural hypotension
- Chronic musculoskeletal or cardiorespiratory conditions
- Advanced age and frailty/sarcopaenia
- Psychiatric illness including anxiety/depression/substance use/withdrawal - not just older persons

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So can JMO's do something about falls?

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So what can JMO's do?

On admission:

- Identify potential medical falls risk factors
- Liaise with medical team, nursing staff and family

During Admission:

- Manage reversible causes of falls eg medication and hydration
- Be aware of prescribing medications that can increase falls risk, and consider timing of meds eg diuretics
- Consider patient bedside safety and amenity eg walking aids, call bell, bedside table etc.

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Other things JMO's might be involved in for falls prevention

- Safety Huddles
- Post - Fall Huddles
- Intentional Rounding

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- **Safety Huddles** are a brief, focused and structured exchange of information about potential or existing safety risks which may affect patients/residents or staff
- Safety Huddles are held at the beginning of the day and at every shift changeover with all relevant staff.
- **Intentional Rounding** Patients are identified at risk at handover or a Safety Huddle, then rounded/checked on every 1-2 hours and asked if they need anything, want to go to toilet, are comfortable, in pain, provided with an opportunity for a drink, and observed as to distress or level of sedation.
- **Post-Fall Huddles** are a reactive debrief which takes place as soon as possible after a fall has occurred with patient/carer.
- Purpose: To identify what happened, including whether the harm or harm risk was related to patient factors or systems and processes; and to develop plans to prevent a reoccurrence.

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If an inpatient falls…..

What should *we* do?

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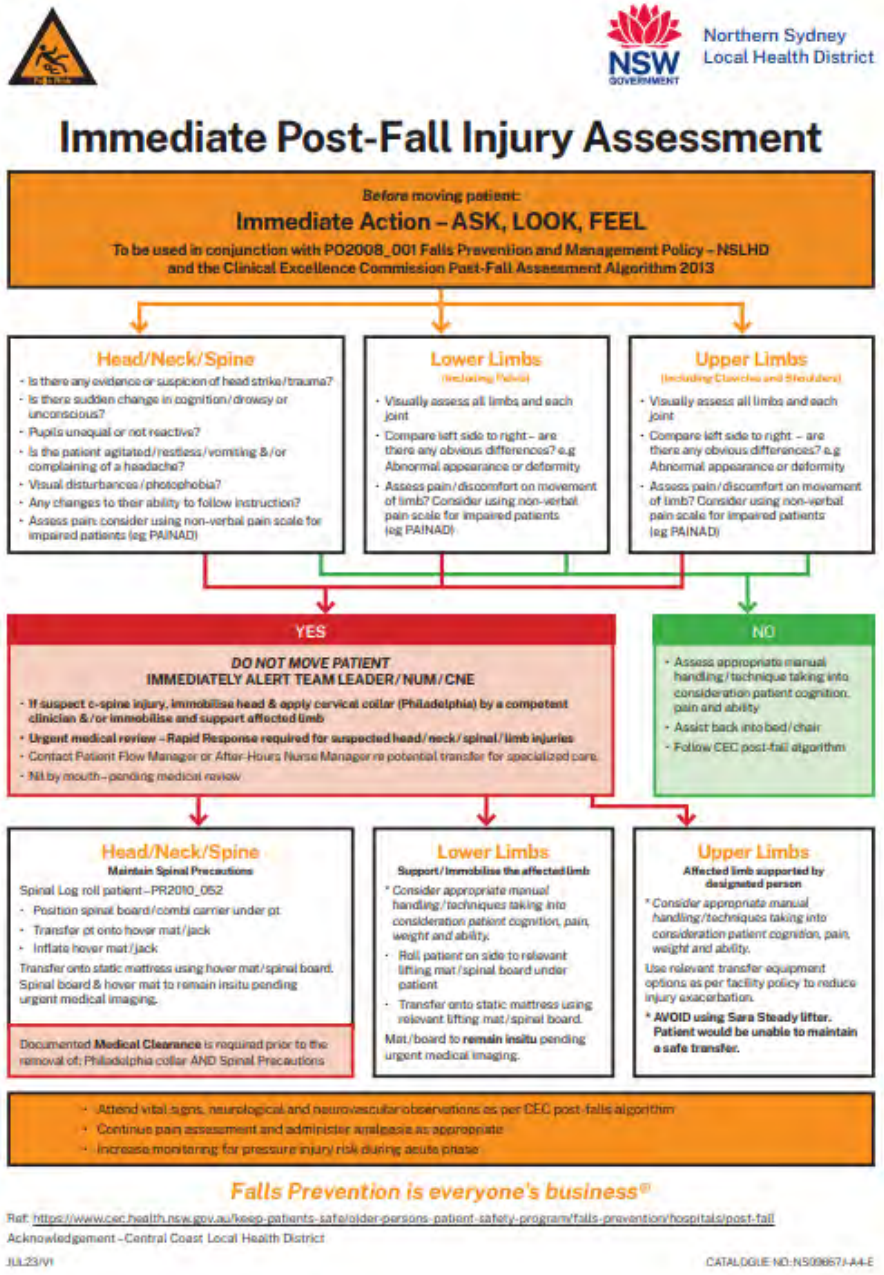
Step 1

Immediate Post-fall injury assessment.

We should never make assumptions that a *simple* or unwitnessed fall won't result in an injury – we need to appropriately assess the patient head-to-toe using a 'high level of enquiry'.

Particularly when a fall is unwitnessed

After a fall – **leave** the patient on the floor *if considered safe,* and conduct injury assessment/medical review, ***before*** moving patient back into bed or chair.



Northern Sydney Local Health District

Immediate Post-Fall Injury Assessment

Before moving patient:

Immediate Action – ASK, LOOK, FEEL

To be used in conjunction with PO2008_001 Falls Prevention and Management Policy – NSLHD and the Clinical Excellence Commission Post-Fall Assessment Algorithm 2013

Head/Neck/Spine

- Is there any evidence or suspicion of head strike/trauma?
- Is there sudden change in cognition/drowsy or unconscious?
- Pupils unequal or not reactive?
- Is the patient agitated/restless/vomiting &/or complaining of a headache?
- Visual disturbances/photophobia?
- Any changes to their ability to follow instruction?
- Assess pain: consider using non-verbal pain scale for impaired patients (eg PAINAD)

Lower Limbs (including Pelvis)

- Visually assess all limbs and each joint
- Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity
- Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)

Upper Limbs (including Clavicles and Shoulders)

- Visually assess all limbs and each joint
- Compare left side to right – are there any obvious differences? e.g Abnormal appearance or deformity
- Assess pain/discomfort on movement of limb? Consider using non-verbal pain scale for impaired patients (eg PAINAD)

YES

DO NOT MOVE PATIENT
IMMEDIATELY ALERT TEAM LEADER/NUM/CNE

- **If suspect c-spine injury, immobilise head & apply cervical collar (Philadelphia) by a competent clinician &/or immobilise and support affected limb**
- **Urgent medical review – Rapid Response required for suspected head/neck/spinal/limb injuries**
- Contact Patient Flow Manager or After-Hours Nurse Manager re potential transfer for specialized care.
- Nil by mouth – pending medical review

NO

- Assess appropriate manual handling/technique taking into consideration patient cognition, pain and ability
- Assist back into bed/chair
- Follow CEC post-fall algorithm

Head/Neck/Spine
Maintain Spinal Precautions

Spinal Log roll patient – PR2010_052

- Position spinal board/combi carrier under pt
- Transfer pt onto hover mat/jack
- Inflate hover mat/jack

Transfer onto static mattress using hover mat/spinal board. Spinal board & hover mat to remain in situ pending urgent medical imaging.

Documented **Medical Clearance** is required prior to the removal of: Philadelphia collar AND Spinal Precautions

Lower Limbs
Support/Immobilise the affected limb

- * Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.
- Roll patient on side to relevant lifting mat/spinal board under patient
- Transfer onto static mattress using relevant lifting mat/spinal board.

Mat/board to **remain in situ** pending urgent medical imaging.

Upper Limbs
Affected limb supported by designated person

- * Consider appropriate manual handling/techniques taking into consideration patient cognition, pain, weight and ability.

Use relevant transfer equipment options as per facility policy to reduce injury exacerbation.

- * **AVOID using Sara Steady lifter. Patient would be unable to maintain a safe transfer.**

- Attend vital signs, neurological and neurovascular observations as per CEC post-falls algorithm
- Continue pain assessment and administer analgesia as appropriate
- Increase monitoring for pressure injury risk during acute phase

Falls Prevention is everyone's business

Ref: https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-program/falls-prevention/hospitals/post-fall

Acknowledgement – Central Coast Local Health District

JUL23/V1

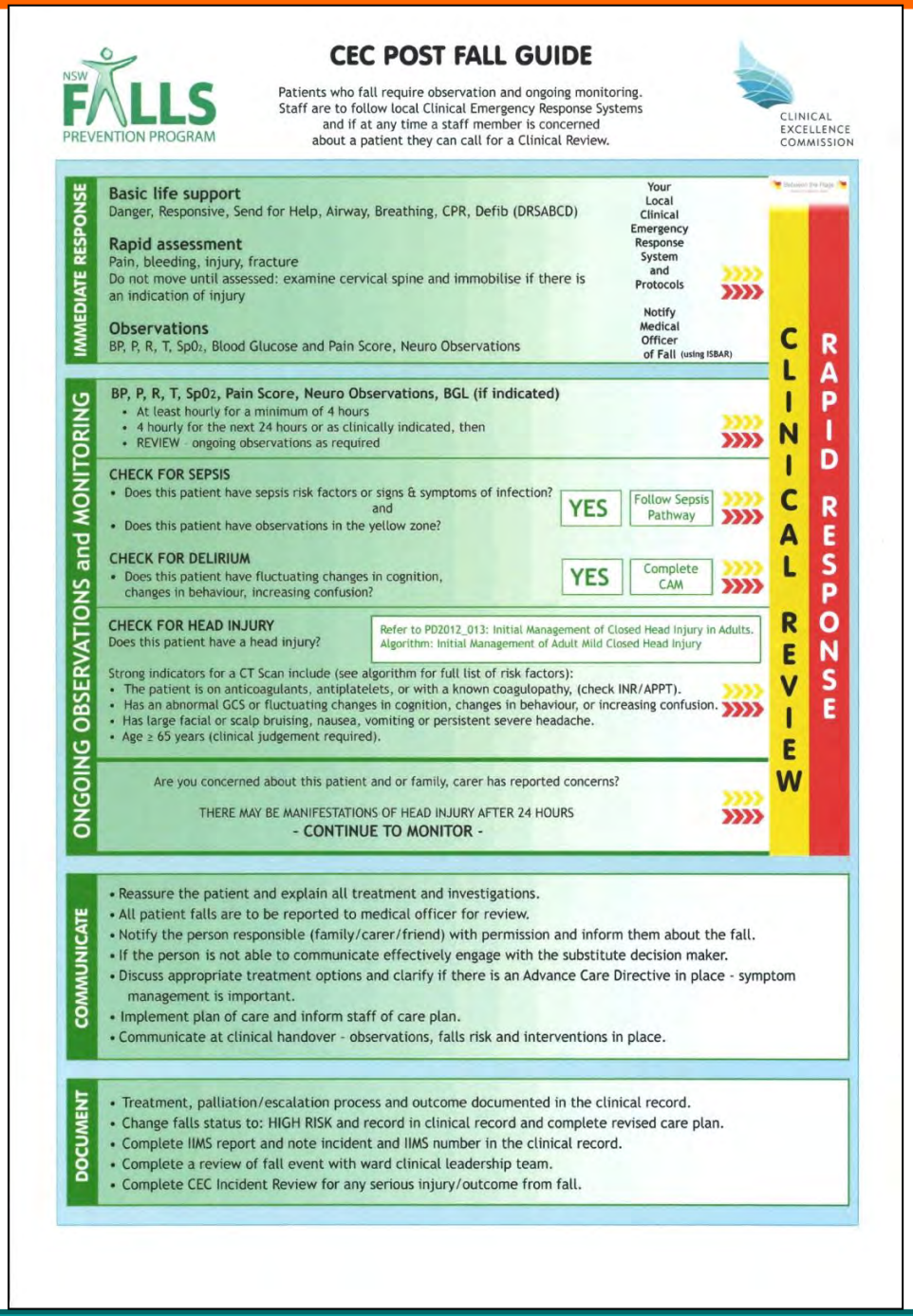
CATALOGUE NO: NS09867-A4-E

Step 2

Clinical Excellence Commission (CEC) Post Fall Guide

- Importance of neuro obs hourly for at least 4 hours, and for 4/24 as clinically indicated.

- **Remember most falls are unwitnessed**



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CEC POST FALL GUIDE

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Emergency Response Systems and if at any time a staff member is concerned about a patient they can call for a Clinical Review.

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IMMEDIATE RESPONSE

Basic life support
Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABCD)

Rapid assessment
Pain, bleeding, injury, fracture
Do not move until assessed: examine cervical spine and immobilise if there is an indication of injury

Observations
BP, P, R, T, SpO_2, Blood Glucose and Pain Score, Neuro Observations

Your Local Clinical Emergency Response System and Protocols

Notify Medical Officer of Fall (using ISBAR)

ONGOING OBSERVATIONS and MONITORING

BP, P, R, T, SpO_2, Pain Score, Neuro Observations, BGL (if indicated)
- At least hourly for a minimum of 4 hours
- 4 hourly for the next 24 hours or as clinically indicated, then
- REVIEW - ongoing observations as required

CHECK FOR SEPSIS
- Does this patient have sepsis risk factors or signs & symptoms of infection?
  and
- Does this patient have observations in the yellow zone?

YES → Follow Sepsis Pathway

CHECK FOR DELIRIUM
- Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion?

YES → Complete CAM

CHECK FOR HEAD INJURY
Does this patient have a head injury?

Refer to PD2012_013: Initial Management of Closed Head Injury in Adults.
Algorithm: Initial Management of Adult Mild Closed Head Injury

Strong indicators for a CT Scan include (see algorithm for full list of risk factors):
- The patient is on anticoagulants, antiplatelets, or with a known coagulopathy, (check INR/APPT).
- Has an abnormal GCS or fluctuating changes in cognition, changes in behaviour, or increasing confusion.
- Has large facial or scalp bruising, nausea, vomiting or persistent severe headache.
- Age ≥ 65 years (clinical judgement required).

Are you concerned about this patient and or family, carer has reported concerns?

THERE MAY BE MANIFESTATIONS OF HEAD INJURY AFTER 24 HOURS
- CONTINUE TO MONITOR -

CLINICAL REVIEW

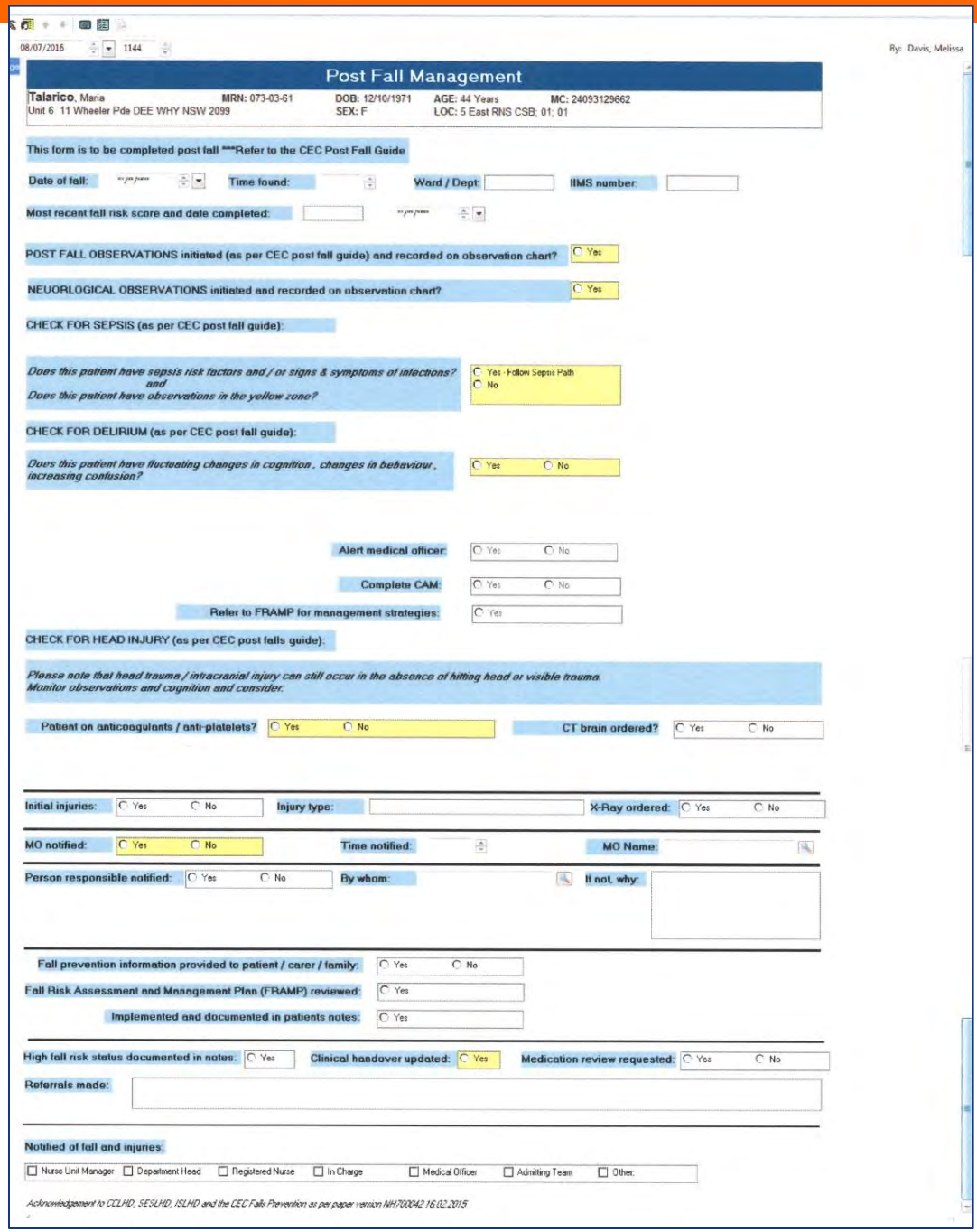
RAPID RESPONSE

COMMUNICATE
- Reassure the patient and explain all treatment and investigations.
- All patient falls are to be reported to medical officer for review.
- Notify the person responsible (family/carer/friend) with permission and inform them about the fall.
- If the person is not able to communicate effectively engage with the substitute decision maker.
- Discuss appropriate treatment options and clarify if there is an Advance Care Directive in place - symptom management is important.
- Implement plan of care and inform staff of care plan.
- Communicate at clinical handover - observations, falls risk and interventions in place.

DOCUMENT
- Treatment, palliation/escalation process and outcome documented in the clinical record.
- Change falls status to: HIGH RISK and record in clinical record and complete revised care plan.
- Complete IIMS report and note incident and IIMS number in the clinical record.
- Complete a review of fall event with ward clinical leadership team.
- Complete CEC Incident Review for any serious injury/outcome from fall.

Post Fall Management Form

After a patient fall, nurses fill out Post Fall Management Form in eMR2



08/07/2016 1144 By: Davis, Melissa

Post Fall Management

Talarico, Maria MRN: 073-03-61 DOB: 12/10/1971 AGE: 44 Years MC: 24093129662
Unit 6 11 Wheeler Pde DEE WHY NSW 2099 SEX: F LOC: 5 East RNS CSB; 01; 01

This form is to be completed post fall ***Refer to the CEC Post Fall Guide

Date of fall: Time found: Ward / Dept: IIMS number:

Most recent fall risk score and date completed:

POST FALL OBSERVATIONS initiated (as per CEC post fall guide) and recorded on observation chart? Yes

NEUORLOGICAL OBSERVATIONS initiated and recorded on observation chart? Yes

CHECK FOR SEPSIS (as per CEC post fall guide):

Does this patient have sepsis risk factors and / or signs & symptoms of infections?
and
Does this patient have observations in the yellow zone?
Yes - Follow Sepsis Path / No

CHECK FOR DELIRIUM (as per CEC post fall guide):

Does this patient have fluctuating changes in cognition , changes in behaviour , increasing confusion? Yes No

Alert medical officer: Yes No

Complete CAM: Yes No

Refer to FRAMP for management strategies: Yes

CHECK FOR HEAD INJURY (as per CEC post falls guide):

Please note that head trauma / intracranial injury can still occur in the absence of hitting head or visible trauma. Monitor observations and cognition and consider.

Patient on anticoagulants / anti-platelets? Yes No CT brain ordered? Yes No

Initial injuries: Yes No Injury type: X-Ray ordered: Yes No

MO notified: Yes No Time notified: MO Name:

Person responsible notified: Yes No By whom: If not, why:

Fall prevention information provided to patient / carer / family: Yes No

Fall Risk Assessment and Management Plan (FRAMP) reviewed: Yes

Implemented and documented in patients notes: Yes

High fall risk status documented in notes: Yes Clinical handover updated: Yes Medication review requested: Yes No

Referrals made:

Notified of fall and injuries:

Nurse Unit Manager Department Head Registered Nurse In Charge Medical Officer Admitting Team Other:

Acknowledgement to CCLHD, SESLHD, ISLHD and the CEC Falls Prevention as per paper version NH700042 16.02.2015

At Discharge Planning

- Communicate falls risk status and ongoing recommendations/referrals to patient, nominated Carers and relevant service providers
- Use eMR Discharge to flag falls risk and to make recommendations to
  - GP's
  - Aged Care Facilities
  - Community Health Services

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Just a word about Bedrails and Non-slip Socks…..

Should they be used?

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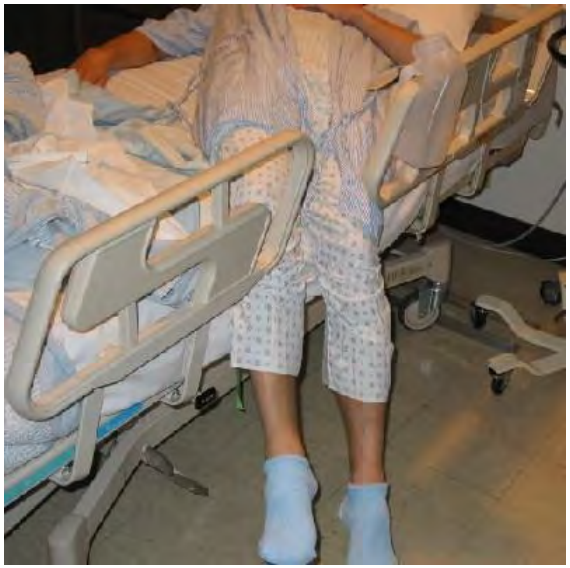
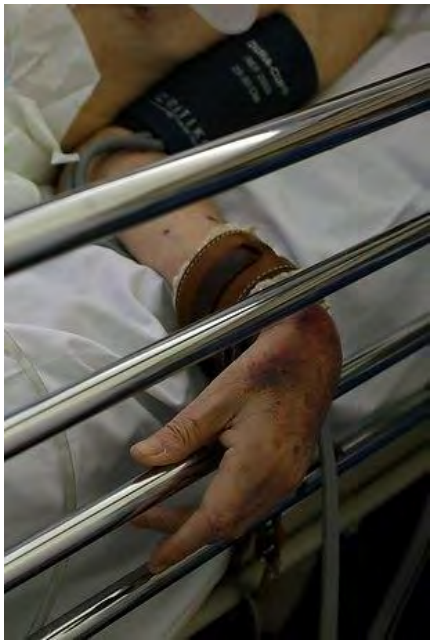
Bedrails.....





- Bedrails **must not** be used in acute and sub/acute care settings as a **primary means** of preventing falls in adults
- Bedrails are **not** to be **used** for **confused patients**
- **Bedrails must never be used as a form of restraint**
- **If you see a bedrail up or are asked to put one up – check with nursing staff**

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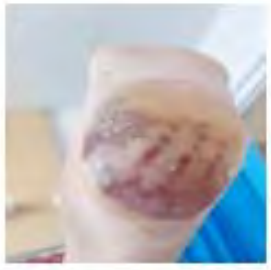
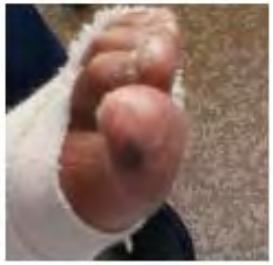
Non-slip socks – a caution

- Non-slip socks are *not* an evidence-based falls prevention strategy or substitute for appropriate and safe footwear.
- Inappropriate provision and use of non-slip socks has been associated with adverse events such as: increased risk of pressure injuries, hygiene concerns, and infection control risks.
- Co-morbidities leading to increased risk include:
  - Lower limb infections, wounds/surgical procedures, vascular disease, diabetes, sensation, identified risk of pressure injuries, lower limb oedema, impaired lower limb sensation, peripheral neuropathy, medications that compromise skin integrity, and existing chronic foot conditions.
  - Inpatients with a shuffling gait and non-socks are at increased risk of falls.
- NSW Safety Notice issued by Clinical Excellence Commission in 2022 to address these concerns.



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Falls Prevention
JMO Top Tips

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What *you* can do to prevent your patients falling

- Is your patient cognitively impaired? Determine delirium v dementia v delirium + dementia
- Assess using relevant tools eg 4AT or CAM, MMSE, MOCA
- Discuss with family/Carer
- Document and communicate outcome

- Is your patient safe on their feet? See if they can transfer from bed and stand unsupported/walk on the spot.
- Refer to PT for full assessment
- Document and communicate findings

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Medication Review for falls prevention

- Is your patient taking culprit medications?

- **We know -** medications linked with falls include: psychotropic, benzodiazepines, cardiovascular, analgesics / opioids, hypnosedatives, antidepressants, opioids, anticholinergics, diuretics - especially these at night.
- Many common drugs have low anticholinergic activity which can be cumulative (eg warfarin, digoxin, B-blockers, diuretics)
- Patients with MCI/dementia at increased risk of anticholinergic SEs incl hypotension, confusion, mydriasis

- **So**- if the above or other new medications are *prescribed or ceased*, consideration should be given to their potential adverse effect on falls risk.
- **Night sedation -** use must be reviewed by medical team with the aim of using the appropriate amount of medication if required.

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Then:

Following review of medications:

- Provide the patient and their carer with an explanation of newly prescribed medications or changes to prescriptions – preferably in writing.
- Ensure all changes made to medications are conveyed to the patient's general practitioner.

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What *you* can do to prevent your patients falling

- Is your patient hypotensive? Idiopathic v iatrogenic
- Check BPs lying v sitting v standing v after mobilising'
- Are they dehydrated?
- Are they drinking enough?
- Consider a fluid intake/balance chart

JMO Post-fall Management

- Assess patient's general condition and injuries insitu
- *Always* consider closed head injury in frail elderly patients, especially when the fall is unwitnessed
- Consideration of CT scanning for head injury for those who hit head, are ≥65 yrs, on anticoagulants and have cognitive change
- CTB and neuro obs for older patients on antiplatelet drugs, DOACs or warfarin
- A sleepy patient may have a serious concussion
- A fall may indicate a change in condition;

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JMO Post-fall assessment- top considerations.

- If JMO is concerned regarding a patient post fall, they should discuss the patient with the attending Registrar or Consultant.
- The on-call geriatrician is available after hours for phone advice about how to proceed with post fall management
- Consultants will want to know if their patients have had a serious fall
- Contact patient's family, even if only minor injury, but especially if there is significant bruising, particularly facial as this can look quite confronting
- Remember that families will often regard a fall/injury as a failure of care
- Review medical conditions and medications
- Recommend Physio mobility review ASAP

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For further support:

Your Facility Falls Committee representative:

- **Senior Medical and Nursing**

- **or**

Margaret Armstrong

NSLHD Falls Prevention Coordinator.

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Ph 04340 11008

Falls Prevention®
is *everyone's* business

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Falls Prevention Resources/ Referral Considerations

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'Stepping On' is a **free** falls prevention group program for older, community dwelling people including those living independently in retirement villages. 65+ who have had a fall or are fearful of falling:

- The program consists of seven weekly 2 hour group sessions, with a booster session 3 months after completion.
- Participants must be able to walk independently or with a walking stick and the program is not generally suitable for people with dementia or neuromuscular conditions.

For classes see:
Nadia Williams- Contact: 0401 715 845 or
www.activeandhealthy.nsw.gov.au

Royal Rehab
The Rehabilitation & Disability Support Network

NSW GOVERNMENT Health

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HEALTHY LIFESTYLE

Get Fit • Feel Great • Have Fun

- Organised physical activity classes for older adults.
- Conducted by trained professionals
- Community venues
- Courses are suitable for beginners and those who exercise regularly.

- Aqua Exercise
- Yoga
- Gentle and Active Exercise
- Pilates Strength training
- Upright and Active
- Tai Chi and gentle Tai Chi
- Zumba Gold

HEALTHY LIFESTYLE

02 8877 5300

www.nshealthpromotion.com.au

Courses cost $120, per term,

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CEC Falls Flyers for staff, patients/carers.

http://www.cec.health.nsw.gov.au/patient-safety-programs/adult_patient_safety/falls_prevention/information_for_patients

Falls fact sheets that are able to be downloaded for free or ordered.


NSW FALLS PREVENTION PROGRAM

How to get up if you have a fall

Know what to do - it is important to have an emergency plan:

- Call for help - keep a list of family and friends' phone numbers near the phone, or program them into the phone for one-touch dialling
- Keep a phone within reach, in case it is hard to get up
- Consider a device that raises an alarm in case of an emergency
- Let family and friends know how to get into your house if you can't let them in.

1. Roll onto your side
2. Crawl or drag yourself to a chair
3. Face the chair and get up on your knee
4. Bring one knee forward and put that foot on the floor, then use the chair to push up with your arms, until you are upright enough to pivot your bottom around to sit
5. Rest for a while before standing up

If you can't bend your knees very well, slide along on your bottom, then lift your hips onto something higher, such as stairs. Then you can pull yourself upright again.

You might like to practice these techniques, so if you ever need to get up from the floor, you will feel more confident.

You should see your doctor after a fall if:

- You are taking anticoagulant medicines
- You bump your head, feel drowsy or unwell
- You are worried about your balance
- You have a pain that concerns you.


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Falls Prevention – Healthy eating

Eating a balanced diet is very important for good health, energy, strong bones and muscles.

- As we age, our bones can become fragile and more likely to break.
- Calcium and Vitamin D help keep bones and muscles strong.
- Include three or four serves of calcium-rich foods, such as milk, yoghurt, custard, cheese, sardines and salmon, every day.
- To boost Vitamin D levels, - spend a few minutes in the sun a day before 10am or after 3pm when it is not too hot, in summer. Two to three hours over a week in winter.
- You may need to supplement both calcium and Vitamin D. Check with your doctor.
- Eat three good meals a day, - or regular smaller meals and snacks, to keep up your energy.
- Each day have a serve of meat, poultry, fish or legumes, and include serves of fruit and vegetables.
- If you have trouble shopping or cooking for yourself, services are available. Contact Commonwealth Care Link on 1800 052 222 (free call) for help.

Ambassador for Ageing Noeline Brown

Many people don't drink enough fluids.

- Lack of fluids can lead to dehydration, weakness and dizziness, which can increase your risk of a fall.
- Drink around 6-8 glasses of fluid a day.
- Fluids can include water, tea, coffee, fruit juice and milk.
- Nourishing fluids, such as milk shakes, smoothies, milky coffee and soups are good, if you are not eating well.


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Falls Prevention – Medications

If you take anticoagulant medicines (blood thinners), always see your doctor if you have a fall. You may be at risk of severe injury and bleeding.

- Some medications can make you dizzy or drowsy and may increase your risk of a fall.
- If you start taking a new medicine, change brands, take multiple medicines, or change your normal dose, the chance of experiencing side-effects increases. Talk to your doctor if you are concerned.
- Certain over -the-counter medications may react with your prescription medicines and cause problems.
- Medicines for anxiety depression or sleep difficulties make falls more likely.

People who take four or more medications a day are at increased risk of falling

What you can do

- Do not take anyone else's prescribed medication.
- Read medication labels in good light and follow the instructions carefully.
- Do not use out-of-date medications. Return them to your pharmacist.
- Talk to your doctor or pharmacist regularly to review your medications, including any herbs or supplements.
- Ask your pharmacist about packaging your medications in a dosette box or Webster pack to help you manage them.
- Have an up-to-date list of your medications. A medication card can be useful.


NSW FALLS PREVENTION PROGRAM

Falls Prevention – Strength and balance exercises

Staying physically active is the single most important thing we can do to remain fit and independent.

- As we grow older we lose muscle strength and our sense of balance. This can lead to a fall.
- The more active we remain, the better the chance we have of keeping our muscles strong and our joints mobile.
- To reduce the risk of injury from a fall it is important to include activities that improve your balance and increase your strength.

Noeline Brown Ambassador for Ageing demonstrating Tai Chi. Photo courtesy of the Australian Government Department of Health and Ageing

www.activeandhealthy.nsw.gov.au

Designed for

What can you do?

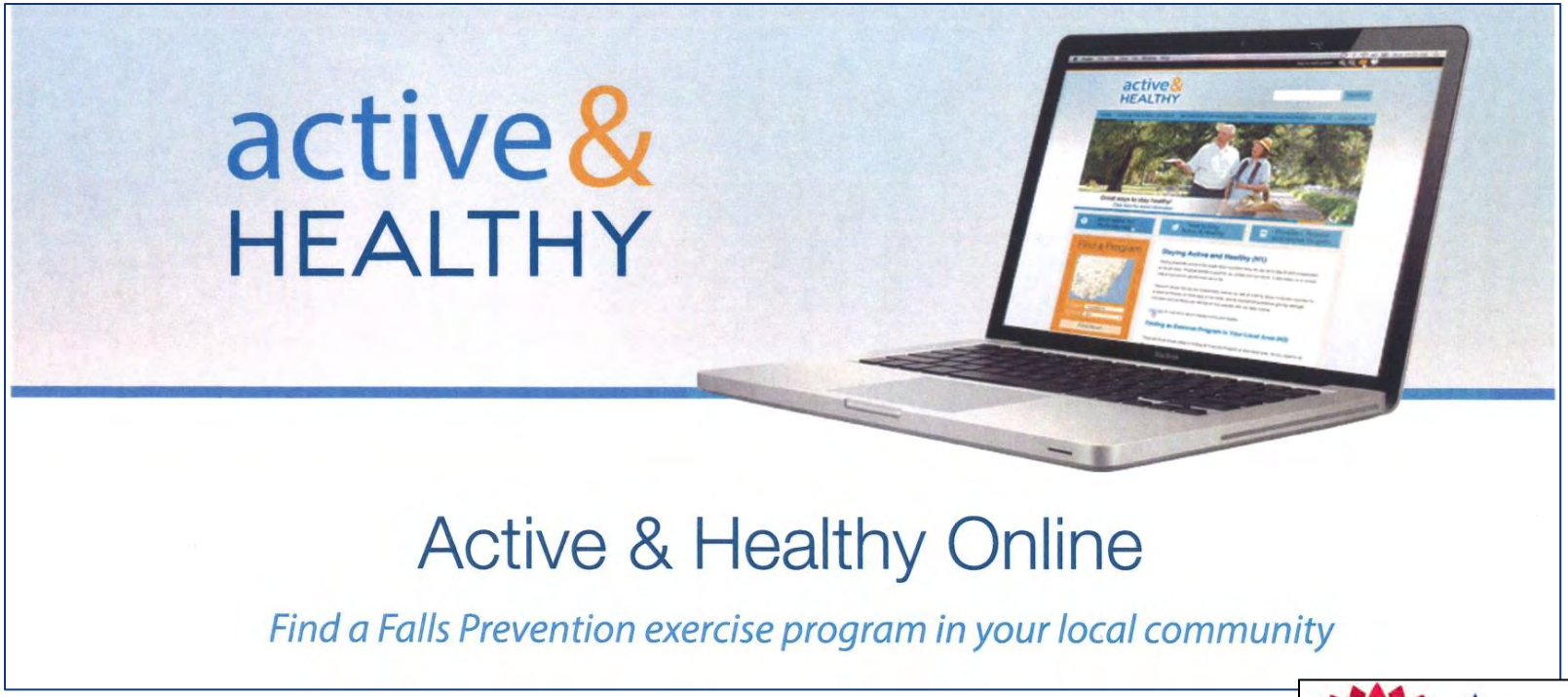
Tai Chi, home exercises, dancing, gym sessions, group exercises, Pilates and Yoga activities are very good for improving balance and strength.

To find an exercise program in your local area go to www.activeandhealthy.nsw.gov.au

Active and Healthy Website:

State wide consumer and professional resource

www.activeandhealthy.nsw.gov.au



Find*:*

- ***Exercise Programs*** in local area
- **Stepping On** classes
- ***Staying Active and On Your Feet*** publication
- Other downloadable resources

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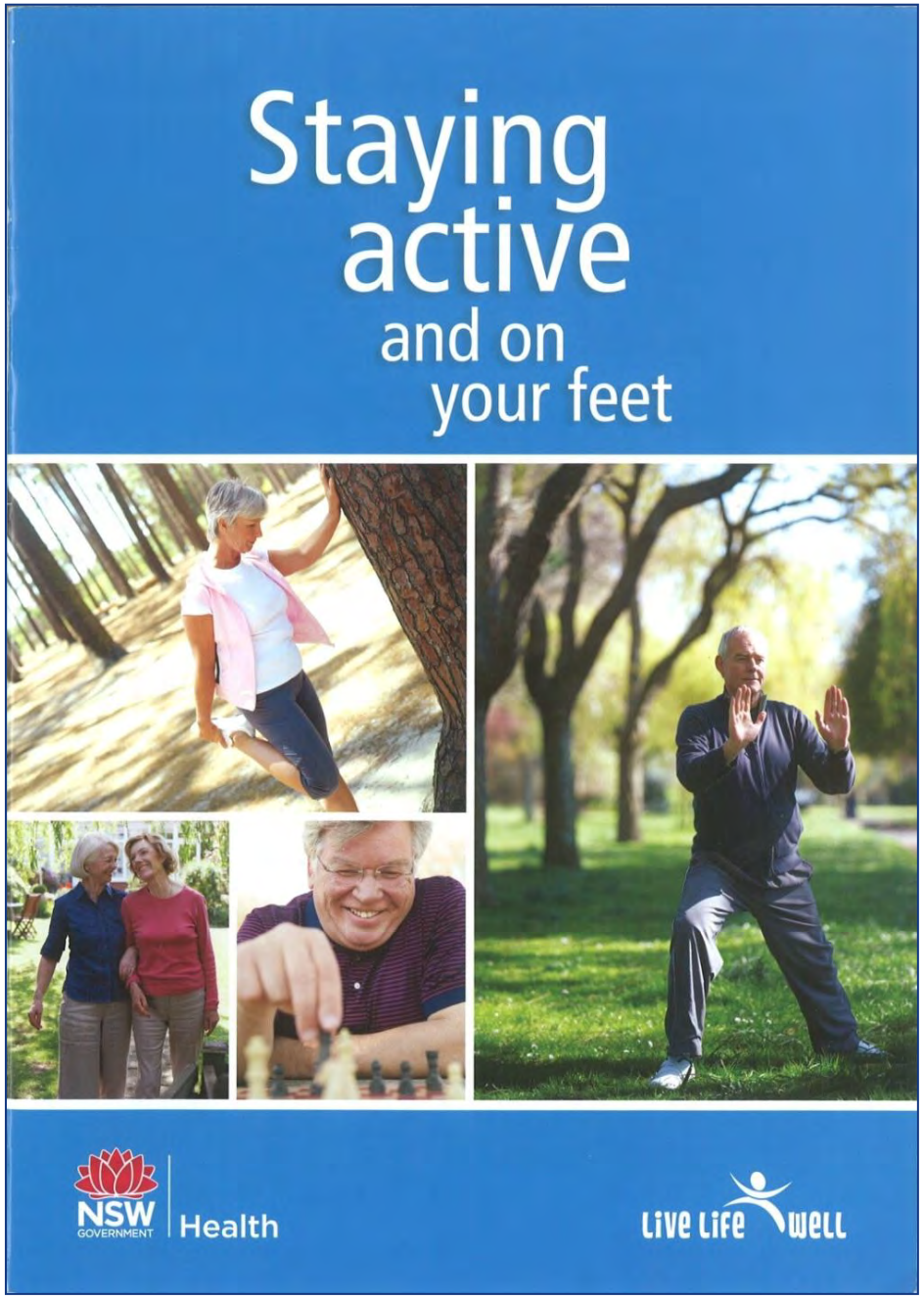
‘Staying Active and on your feet’

FREE resource booklet

Health Professionals are able to order this resource on-line: from the Active and Healthy Website

http://www.activeandhealthy.nsw.gov.au/your_active_and_healthy_guide

NSW GOVERNMENT Health



Frailty education for the multidisciplinary team: a HETI podcast series

My Health Learning: https://spzsso.cit.health.nsw.gov.au/oaam_server/login.do

Course Code: 320455651

Duration (total): 55 minutes; 5 episodes of approximately 8 – 12 minutes each.

Learning Outcomes:

On completion of this learning participants will be able to:

- Identify the characteristics of frailty as a medical syndrome
- Explain why conversations on frailty are important to improve patient care and outcomes
- Contribute to assessment and treatment of frailty within a multidisciplinary team
- Describe current developments and guidelines that inform the management of frailty

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