CPCN GAP Fall Prevention
Care Map

Falls Referral Received
from
SMH, AHS, Patient/Family, Physician, Community Providers

Telephone Triage by GAP RN* using
Fall Risk Management Pathway

Patient appropriate for fall prevention program

Initial Fall Prevention assessment appointment booked

Initial Assessment by RN & CoE Physician

Fall Risk Factors Identified

- Devise Action Plan with Patient
- Referral to Exercise Specialist (ES) for assessment
- Referral for appropriate exercise intervention (8 week PCN Balance & Mobility exercise program or AHS HLC Better Balance Program)
- Internal referrals as needed (PCN Dietitian, Pharmacist, Mental Health Liaison, BHC)
- External referrals as needed to other health &/or community providers (i.e. AHS HC/HLP)
- Letter to family physician

Exercise Intervention Complete

- Follow up ES assessment
- Provide further exercise intervention recommendations

3 Month Phone Call Follow Up by RN

- Assess patient engagement & fall status
- Further triage/intervention recommendations if needed

Patient ***not*** appropriate for GAP Fall Prevention program

- **Deemed not a fall risk -** Recommend exercises or activities to maintain balance, strength & mobility; letter sent to family physician
- **Deemed high fall risk with multiple concerns** – recommendation made to family physician to refer patient for GAP assessment

Patient Discharged
- requires **no** further assistance to manage health goals

6 Month Reassessment by RN & CoE Physician

- Assess progress & achievement of patient's health goals per their action plan
- Provide further recommendations to manage health goals
- Patient is discharged with recommendations to family physician via letter

***Notes** - If at any point in this care map a patient is deemed to require emergent care, transport will be arranged by EMS and the physician will be made aware