Preventing Patient Falls Across the Care Continuum

Wednesday, April 30th, 2014
Speaker

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Learning Objectives

1. Explain why every hospital should have a falls program
2. Describe what constitutes a fall
3. Recall the intrinsic and extrinsic causes of falls
Falls is one of the 34 Safe Practices for Better Healthcare by NQF (Updated April 2010 and March 2011)

Safe Practice 33 is on Falls Prevention
- Hospitals and other healthcare facilities should take action to prevent patient falls and reduce fall-related injuries by implement evidenced based interventions

Safe Practice 4 includes falls as one of the identification and mitigation of risks in healthcare
- Need to monitor the effectiveness of the falls programs including reduction strategies, environmental redesign, and patient/family education
34 Safe Practice Number 33 on Falls

- Have a fall reduction program
- Program must do an appropriate evaluation of the patient
- Must include interventions based on risk
- Staff must be educated on fall reduction program
- Patient and family is educated on program
- Evaluate the effectiveness of the falls program
- Remember you need organizational support for a fall prevention program!

The National Quality Forum (NQF) initial list of serious events that should be publicly reported was published in 2002 which was updated in 2006.

Updated in 2011

Called Serious Reportable Events in Healthcare or never events

It identified 29 adverse events that were considered to be largely preventable

This document would include death or disability associated with a fall while being cared for by the facility.
CMS Hospital Acquired Conditions (HACs)

- CMS has HACs in which there will be no additional payment for Medicare payments
- This includes hospital acquired injuries, fractures, dislocations, crushing injury, burn, and patient falls
  - Falls is the number one HAC
- Data when this was introduced showed 2,591 cases at an average cost of $24,962 for fiscal year 2006
- There is a business case for falls (AHRQ, 2013)
Cost of Falls

- Another study found the cost for fallers with serious injury was $13,316.00 more than non-fallers

- One study found 31-51% of falls in hospitals resulted in some injury

- Fall related injuries account for up to 15% of rehospitalizations in the first month after discharge
  - Fall and Injury Prevention, Leanne Currie 2008, AHRQ Patient Safety Handbook for Nurses
## Conditions for Which Medicare Will No Longer Pay More If Acquired during an Inpatient Stay.

<table>
<thead>
<tr>
<th>Condition</th>
<th>No. of Medicare Cases in Fiscal Year 2006</th>
<th>Average Medicare Payment for Admissions in Which Condition Was Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Object left in patient during surgery</td>
<td>764</td>
<td>$61,962</td>
</tr>
<tr>
<td>Air embolism</td>
<td>45</td>
<td>$66,007</td>
</tr>
<tr>
<td>Blood incompatibility</td>
<td>33</td>
<td>$46,492</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
<td>11,780</td>
<td>$40,347</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>322,946</td>
<td>$40,381</td>
</tr>
<tr>
<td>Vascular-catheter–associated infection†</td>
<td>Unknown</td>
<td>$64,894*</td>
</tr>
<tr>
<td>Mediastinitis after coronary-artery bypass grafting</td>
<td>108</td>
<td>$304,747</td>
</tr>
<tr>
<td>Fall from bed</td>
<td>2,591</td>
<td>$24,962</td>
</tr>
</tbody>
</table>

Data are from the *Federal Register.*

Data are unknown because a unique code for this condition was introduced for fiscal year 2008.

Rosenthal MB., *NEJM.* 2007;357(16):1573-75

† insert: Shannon RP., *AJMQ.* 2006:21(6):7S-16S – Dollar value is excess costs
Healthcare Associated Falls

- 2-20% of patients will have a fall in the hospital
- Higher rates of falls on rehab, geriatric and neurosurgery units
- Fall related injuries account for 6% of all medical expenditures for patients 65 or older
- 23-40% will have an injury an 1.5-8% will be a major injury
- Associated with increased charges of $4,233
  - Falls and trauma in hospital is hospital acquired condition with no additional payment
Overview

- Between 700,000 and 1 million people in the US fall every year
- About one-third of them can be prevented
- CMS has not reimbursed hospitals since 2008 for certain type of traumatic injuries that occur and many result from falls
- Fall prevention involves managing patient’s under lying fall risks
  - Problems with walking and transfer, medication side effects, confusion, toileting needs, etc.
FOCUSING ON PATIENTS TO REDUCE FALLS

GUNDERSEN LUTHERAN HEALTH SYSTEM

◆ La Crosse, WI
◆ 325 beds
◆ www.gundluth.org

A physician-led health system, Gundersen Lutheran is comprised of a hospital, a multi-specialty group medical practices, 42 regional community clinics, four nursing homes, home care, behavioral health services, vision centers, pharmacies and air and ground ambulances. As a tertiary referral

THE PROBLEM

After examining hospital data to pinpoint opportunities to improve, Gundersen Lutheran focused on patient falls. Patient falls made up the second-largest category of reported incidents for Gundersen Lutheran, after medication events. “It was clear everyone was trying hard, but there was no systemic or organization-wide approach to falls,” says Kathy Klock, senior vice president of operations.

THE SOLUTION

Gundersen Lutheran launched a formal program in 2008 to lower the number of patient falls, with an initial focus on achieving no falls with home care. Jeffrey

In 2007, a team of Gundersen Lutheran physicians, nurses, pharmacists, quality professionals, a patient falls expert and other hospital disciplines set out to build a systematic approach to preventing inpatient falls. Drawing on best practices from other organizations and research, it focused on five major areas that could affect the incidence of falls:

◆ Medication—Pharmacy made recommendations for specific conditions, when possible, to minimize dizziness, confusion and other symptoms associated with falls

◆ Patient and family education—A patient education sheet about the risks of falls and how to prevent them was developed

◆ Environment—An interdisciplinary team assessed all aspects of the hospital environment to identify and correct problems that might contribute to falls

◆ A Culture of Safety—This program was targeted to all employees, and focused on education, observation and feedback

◆ A Patient-Centered Approach—A great deal of attention was placed on patient-centered care, including inpatient and outpatient care

12
What 5 Things Did They Do?

- **Medication**-Pharmacy made recommendations for specific conditions, when possible, to minimize dizziness, confusion and other symptoms associated with falls.

- Patient and family **education**-A patient education sheet about the risks of falls and preventative measures was developed.
  - A registered nurse reviews the sheet with patients and families on admission and reinforces the information each shift.
5 Things to Prevent Falls

- **Safe room setup**- Includes an environment that is free of obstacles and clutter and a patient’s call light and personal items are within reach.

- **Safety signage**- Caution posters that encourage patients to call for help are displayed in all patient rooms and bathrooms.

- **Rounding**- Created a log that nursing staff fills out each hour with time and initials that confirms staff checks for pain, bathroom needs and positioning.
Bed trapeze
Falls prevention poster
Non-exit side rails up for support
Exit side head rail up for support and foot rail down at all times.
Movable hand rail (Hemi-walker) always within reach
Non-slip floor mat absorbs fluids, food, & stool, and prevents slips
Bed controls at fingertips
Bed alarm
Bedside commode placed along-side bed (replaces urinal)
Non-skid floor
Room illuminated at all times
More Nurses and Alarms To Reduce Falls

- Study in Journal of Patient Safety discusses hospitals in Washington State must report falls to department of health
  - 11 states must report

- Some hospitals have installed alarms to monitor patients prone to sleepwalking

- But need enough nurses and staff to respond when alarm goes off
  - Hospital reduced falls by 66% by having enough nurses

- Patients given Ambien are four times more likely to fall
More Nurse and Alarms To Reduce Falls

To Reduce Patient Falls, Hospitals Try Alarms, More Nurses

by JOHN RYAN
October 16, 2013 4:54 PM

Listen to the Story
All Things Considered

A bad fall in the hospital can turn a short visit into a long stay.
Is There Conclusive Evidence?

- One study found that there is no conclusive evidence that hospital fall prevention programs can reduce the number of falls or fallers.

- Stated more studies are needed to evaluate the trend toward actively targeting the patient’s most important risk factors.

- So let’s focus on both and newer studies gives us some hope where a program reduced falls.

  - Coussement J. Interventions for Preventing Falls in Acute and Chronic-Care Hospitals: A Systematic Review and Meta-Analysis. JAGS 2008;56:29-36
  - Dykes PC, et al. Fall Prevention in Acute Care Hospitals: A Randomized Controlled Trial. JAMA 2010: 304: 1912-1918
  - Cameron ID. Interventions for Preventing Falls in Older People in Nursing Care Facilities and Hospitals. Cochrane Database Syst Rev 2010;20(1):CD005465
New Studies

- New studies are being published and hospitals should do periodic literature searches on falls.

- Falls committee can ask librarian to send the committee any articles on falls.

- For example, Mayo Clinic study found that the popular sleeping pill Zolpidem (Ambien, Intermezzo, Stilnox, Sublinox) for sleep is correlated with an increase risk of falls (quadruples fall risk).

- Approximately 3% of all patients on this drug fell compared with 0.7% who did not take this drug.

- Source: Journal of Hospital Medicine.
New Studies

- Create a no pass zone
  - Any who see the call light on responds whether it is their patient or not

- Create a personalized recorded message for the call alarm
  - Helps some confused patients in an unfamiliar setting by hearing their name, the language they speak and something personal about the patient

- Put a patient board in every patient room
  - Identify if patient uses a cane, bed alarm, walker, or some other activity such as toileting
AHRQ Toolkit

- AHRQ 2013 toolkit is an excellent resource available at no cost
- It is called “Preventing Falls in Hospitals; A Toolkit for Improving Quality of Care”
- It is a roadmap for preventing of falls in hospitals
- It has many excellent evidence based tools
- States a number of practices have been shown to reduce the occurrence of falls but these practices are not systematically used in all hospitals
  - www.ahrq.gov/legacy/research/ltc/fallpxtoolkit/index.htm
AHRQ Preventing Falls in Hospitals

Preventing Falls in Hospitals
A Toolkit for Improving Quality of Care

Each year, somewhere between 700,000 and 1,000,000 people in the United States fall in the hospital. A fall may result in fractures, lacerations, or internal bleeding, leading to increased health care utilization. Research shows that close to one-third of falls can be prevented. Fall prevention involves managing a patient’s underlying fall risk factors and optimizing the hospital’s physical design and environment. This toolkit focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program.

Select for print version (PDF, 3.3 MB) (Plugin Software Help).
Select to download individual sections from the falls prevention toolkit roadmap.

Prepared for:
Agency for Healthcare Research and Quality
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Rockville, MD 20850
www.ahrq.gov

Prepared by:
RAND Corporation
Boston University School of Public Health
ECRI Institute

Contract No. HHSO20201000417I TO #1

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The Challenges of Fall Prevention
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Sections of the Guide
Adaptation of the Guide to Your Organization
Improvement as Puzzle Pieces
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www.ahrq.gov/legacy/research/ltc/fallpxtoolkit/index.html
Preventing Falls in Hospitals
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# A Roadmap to Follow!

## Roadmap

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<th>Action Steps</th>
<th>Tool That Supports Action</th>
<th>Who Should Use The Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>Enlist support of senior leaders</td>
<td><strong>Tool 0A, Introduction and Overview for Stakeholders</strong></td>
<td>Senior manager</td>
</tr>
<tr>
<td>Section 1</td>
<td>Are you ready for this change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Assess the culture of safety in your hospital</td>
<td><strong>Tool 1A, Hospital Survey on Patient Safety Culture</strong></td>
<td>All interdisciplinary team members</td>
</tr>
<tr>
<td>1.2</td>
<td>Evaluate current organizational attention to falls</td>
<td><strong>Tool 1B, Stakeholder Analysis</strong></td>
<td>Implementation Team leader</td>
</tr>
<tr>
<td>1.3</td>
<td>Assess and develop leadership support for the fall prevention program</td>
<td><strong>Tool 1C, Leadership Support Assessment</strong>&lt;br&gt;<strong>Tool 1D, Business Case Form</strong></td>
<td>Implementation Team leader</td>
</tr>
<tr>
<td>1.5</td>
<td>Identify resources that are available and resources that are needed</td>
<td><strong>Tool 1E, Resource Needs Assessment</strong></td>
<td>Implementation Team leader</td>
</tr>
<tr>
<td>1.7</td>
<td>Assess your progress on completing readiness for change activities</td>
<td><strong>Tool 1F, Organizational Readiness Checklist</strong></td>
<td>Implementation Team leader</td>
</tr>
<tr>
<td>Section 2</td>
<td>How will you manage change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Identify your Implementation Team</td>
<td><strong>Tool 2A, Interdisciplinary Team</strong></td>
<td>Implementation Team leader</td>
</tr>
<tr>
<td>2.2</td>
<td>Assess the current status of fall prevention activities in your hospital</td>
<td><strong>Tool 2B, Quality Improvement Process</strong>&lt;br&gt;<strong>Tool 2C, Current Process Analysis</strong></td>
<td>Implementation Team leader, individuals designated by the</td>
</tr>
</tbody>
</table>
AHRQ Toolkit

- Geared at negotiating a change process at your hospital
- Stresses it is an interdisciplinary process
- Has a implementation guide which is organized into six major questions
- Focused on putting preventive strategies into practice
- Have a standing committee to oversee fall program

  - www.rand.org/pubs/working_papers/WR907.html
## AHRQ Falls Plan of Care

### Care Plan

<table>
<thead>
<tr>
<th>GOAL: To reduce likelihood of falls while maintaining dignity and independence</th>
<th>State action taken below (sample provided):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call.</strong> Ensure call bell explained and in reach. Consider alternatives for patients unable to recall use of call bell, e.g., use brass bell, move bed in sight of nurses’ station.</td>
<td>Call bell in reach but may forget, will probably call her daughter’s name instead; moved within earshot of nurses’ station.</td>
</tr>
<tr>
<td><strong>Eyesight.</strong> Ensure eyesight is checked and patient is wearing glasses if needed. Can the patient identify pen/key from bed length away? If eyesight is too poor to identify objects, ask the treating medical provider to review. Ensure glasses/hearing aid are worn or within reach.</td>
<td>Glasses broken in fall at home; family has ordered replacement and hopes to provide it tomorrow. Has fair distance vision without them. Have suggested that the family order a spare pair too.</td>
</tr>
<tr>
<td><strong>Bed and bedrails.</strong> Assess the need for bedrails (refer to policy). If patient is likely to fall from bed, ensure bed is at the lowest possible height unless this would reduce mobility or independence. Consider use of special low bed.</td>
<td>Bedrails not appropriate as this patient can mobilize on her own, even though unsteady, and might be confused enough to climb over. Bed set at right height for safe move from sitting to standing.</td>
</tr>
<tr>
<td><strong>Medication.</strong> Check for medication associated with fall risk, such as antidepressants, sleeping tablets, sedatives, and antipsychotics. Ask the pharmacist to review and make recommendations to treating medical provider (do not stop abruptly).</td>
<td>On temazepam 15 mg qhs for some years; will discuss with pharmacist.</td>
</tr>
<tr>
<td><strong>Mobility.</strong> Determine the patient’s level of mobility and whether actions should be taken to improve or maintain mobility.</td>
<td>Participating in supervised mobility protocol with nursing assistant. Currently able to ambulate 50 feet with front wheeled walker daily.</td>
</tr>
<tr>
<td><strong>Interdisciplinary team.</strong> Ensure medical staff, physical therapist, occupational therapist, social worker, and others on the team are aware of the patient’s risk, frequency, nature, and seriousness of falls (local protocol or pathway would cover expected actions by team members, e.g., cognitive evaluation, osteoporosis check, mobility aid review).</td>
<td>Treating physician aware of patient’s fall risk. Physical and occupational therapy referral sent on 11/14/11. Fall risk noted on discharge plan.</td>
</tr>
<tr>
<td><strong>Footwear.</strong> Check footwear for secure fit.</td>
<td>Patient does not have footwear. Provided with...</td>
</tr>
</tbody>
</table>
# Detailed Action Plan

**Improvement Objective:** Implement standard fall prevention practices within 6 months.

<table>
<thead>
<tr>
<th>Key Interventions/Tasks</th>
<th>Steps To Complete Task and Tools To Use</th>
<th>Team Members Responsible for Task Completion</th>
<th>Target Date for Task Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze current state of fall prevention practices in this organization.</td>
<td>Identify strengths and weaknesses using process mapping and gap analysis. Tool 2C and Tool 2D.</td>
<td>Team leader, RNs</td>
<td>Within 6 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Assess the current state of staff knowledge about fall prevention. Tool 2E.</td>
<td>Education department</td>
<td>Within 6 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Set target goals for improvement.</td>
<td>QI department</td>
<td>Within 8 weeks from initiative start</td>
</tr>
<tr>
<td>Identify the set of prevention practices to be used in redesigned system.</td>
<td>Determine how comprehensive universal fall precautions should be performed.</td>
<td>Implementation Team</td>
<td>Within 12 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Decide which scale or questions will be used for performing fall risk factor assessment.</td>
<td>Implementation Team</td>
<td>Within 12 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Decide which fall prevention activities should be in your program.</td>
<td>Clinical staff members</td>
<td>Within 12 weeks from initiative start</td>
</tr>
<tr>
<td>Assign roles and responsibilities for implementing the redesigned fall prevention practices.</td>
<td>Determine who will complete the fall risk factor assessment on admission. Tool 4A.</td>
<td>Implementation Team</td>
<td>Within 16 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Identify unit champions.</td>
<td>Team leader</td>
<td>Within 16 weeks from initiative start</td>
</tr>
<tr>
<td></td>
<td>Determine how prevention work will be organized at the unit level, such as paths of communication and lines of oversight.</td>
<td>QI team</td>
<td>Within 16 weeks from initiative start</td>
</tr>
<tr>
<td>Put the redesigned set into practice.</td>
<td>Engage staff and get them excited about the changes needed.</td>
<td>Team leader, unit staff</td>
<td>Within 12 weeks from initiative start</td>
</tr>
</tbody>
</table>
ELIMINATE HARM ACROSS THE BOARD

Days Since Last Fall

FALL PREVENTION:
- Conduct fall and injury risk assessment upon admission
- Reassess risk daily and with changes in patient condition
- Implement patient-specific intervention to prevent falls and injury
- Communicate risk across the team; use handoff forms, visual cues, huddles
- Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure); combine with other tasks (vital signs)
- Individualize interventions; use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds
- Review medications (by pharmacist); avoid unnecessary hypnotics and sedatives
- Incorporate multidisciplinary input for falls prevention from PT, OT, MD, RN and PharmD
- Include patients, families and caregivers in efforts to prevent falls; educate regarding fall prevention measures; stay with patient
- Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls

www.hret-hen.org/index.php?option=com_content&view=article&id=5&Itemid=130
The information contained in these resources does not necessarily reflect the views of the Partnership for Patients, the Centers for Medicare and Medicaid Services, The United States Department of Health and Human Services, nor the United States government.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“CMS Improves Patient Safety for Medicare and Medicaid by Addressing Near Events” (U.S. Department of Health &amp; Human Services, Centers for Medicare &amp; Medicaid Services [CMS])</td>
<td>CMS publication. Fact sheet covering new Medicare and Medicaid payment and coverage policies to improve safety for hospitalized patients, including the initiation of new proceedings for “wrong surgery,” a category of “never events.”</td>
</tr>
<tr>
<td>“Serious Reportable Events: Transparency, Accountability Critical to Reducing Medical Errors and Harm” (National Quality Forum)</td>
<td>In 2002, NOF endorsed a list of Serious Reportable Events (SREs) to increase public accountability and consumer access to critical information about healthcare performance. In 2006, NOF updated the list of SREs. There are 28 events and each is classified under one of six categories: surgical, product or device, patient protection, care management, environment, or criminal. The fact sheet includes a list of the 2006 SREs.</td>
</tr>
<tr>
<td>“Patient Safety Indicators Resources” (U.S. Department of Health &amp;</td>
<td>User guides, technical specifications, and development</td>
</tr>
<tr>
<td><strong>Resource</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>&quot;Patient Safety Indicators Resources&quot; (U.S. Department of Health &amp; Human Services, Agency for Healthcare Research and Quality [AHRQ])</td>
<td>User guides, technical specifications, and development materials (such as brochure, link to software, etc.).</td>
</tr>
<tr>
<td>&quot;Inpatient Quality Indicators Resources&quot; (AHRQ)</td>
<td>User guide, technical specifications, and development materials (such as brochure, link to software, etc.).</td>
</tr>
<tr>
<td>&quot;Fall Prevention and Management&quot; (U.S. Department of Veterans Affairs, National Center for Patient Safety [NCPS])</td>
<td>Online assessment and guide to a multi-disciplinary approach to falls prevention and management using a systematic assessment for determining risk and recommended interventions.</td>
</tr>
<tr>
<td>&quot;2004 Falls Toolkit&quot; (NCPS)</td>
<td>Toolkit accompanied by introductory monograph and PowerPoint slide deck.</td>
</tr>
<tr>
<td>&quot;Fatal Falls: Lessons for the Future,&quot; Sentinel Event Alert, Issue 14 (The Joint Commission)</td>
<td>Topic Library Item. Health care organizations that have experienced sentinel events due to falls have identified the root causes and risk reduction strategies included in this issue. In addition, experts have commented on the events and the related root causes and risk reduction strategies. The Joint Commission offers this information for consideration by hospitals, long-term care facilities, and behavioral health care organizations in their continuing efforts to reduce the risk of falls of their patients, residents, or individuals served.</td>
</tr>
<tr>
<td>&quot;Fall Prevention in Hospitals&quot; (Premier Inc.)</td>
<td>Comprehensive falls prevention resource page. Includes definitions &amp; measures, causes of falls, interventions &amp; prevention, risk assessment, prevention program, sample procedures, tools, education &amp; training materials, and resources.</td>
</tr>
<tr>
<td>&quot;Falls Prevention&quot; (Institute for Healthcare Improvement)</td>
<td>Listing of Mentor Hospitals for falls prevention. Includes a quick reference table to find a mentor with similar demographics to the...</td>
</tr>
</tbody>
</table>
Fall Risk Assessment Pa PSA

Welcome to the Pennsylvania Patient Safety Authority Site

Articled from the Advisory

Distractions and Their Impact on Patient Safety
Clinicians encounter distractions on a nearly continuous basis, and these distractions pose a constant threat to patient safety. Analysis of events reported in 2010 and 2011 identified more than 1,000 that could be attributed to distraction.

Read More...

Results of the Opioid Knowledge Assessment from the PA Hospital Engagement Network Adverse Drug Event Collaboration

To address opioid knowledge gaps among practitioners, facilities may consider assessing understanding of opioids and providing training, including assessment of patients, recognizing advancing sedation, and making timely adjustments to the plan of care.

Read More...

Healthcare Outbreaks—Risk Assessment and Mitigation Based on Pathogen, Population, and Environmental Factors: The P2E Concept

Assessment of pathogen, population, and environment (P2E) may help guide infection preventionists as to which pathogens, and in which patient populations, targeted measures may be indicated to establish appropriate outbreak prevention strategies.

Read More...

In the Spotlight

Ensure appropriate care for class III obese patients
Address wrong-site surgery prevention principles
Prevent surgical fires through best practices
Class III obese patients: Is your hospital equipped to care for you?

Read More...
Fall Prevention
It's more than fall risk assessment...

STOP

Be Proactive – Prevent Falls Before They Occur

Consider utilizing the following interventions:

- Physical therapy – strengthening and balance program
- Occupational therapy – ADL/IADL management
- Home health aide referral for assistance with bathing
- Medical/social worker evaluation for social support
- Maintenance exercise program
- Reduce hazards in the home
- Annual vision evaluation (minimum)
- Medication management
- Check postural vital signs
- Nutrition evaluation.
Please press the call button for your nurse to help you go to the bathroom.
We don’t want you to fall and get hurt.
Falls and Mobility

- The goal should focus on prevention and severity of injury from falls and increased immobility
- We need to get patients up and moving
- Immobility causes increased LOS, delirium, pressure ulcers, functional loss, and readmissions
  - Foley catheters increase fall risk
- Study showed 30% of elderly patients had an initial order of bed rest
- Another study showed median amount of time standing or walking is 43 minutes
Falls and Mobility

- Translation means that up ad lib means 97% of the time patients are immobile or 23 hours 17 minutes.
- Immobility or deconditioning may explain why so many patients fall when toileting.
- Immobility creates an increased risk when patients do need to mobilize.
  - Brown CJ et al. The Under recognized Epidemic of Low Mobility During Hospitalization. JAGS 2009;57:1160-1665
  - Early Ambulation and Length of Stay in Older Adults Hospitalized for Acute Illness. Arch Int Med 2010;170:1942-1943
Falls was as a Joint Commission **National Patient Safety Goal** in 2009 but moved to standard in 2010 under PC.01.02.08

- PC.01.02.08 The hospital assesses and manages the patient’s risks for falls

- EP1 Hospital must assess the patient’s risk for falls based on the patient population and setting (elderly, behavioral health, pediatric patients)

- EP2 Hospital implements interventions to reduce falls based on the patient’s assessed risk
PI.01.01.01 The hospital collects data to monitor its performance

EP 38 The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

Note: Examples of outcome indicators to use in the evaluation include number of falls and number and severity of fall-related injuries.
Joint Commission Fall Standard

- Generally a fall assessment is done as part of the initial nursing assessment.
- Based on the assessment, a plan of care is developed.
- The patient interventions are based on what their score is on the fall tool.
- Most have two or three types of interventions depending on the risk.
- Joint Commission abbreviated TJC since no longer called JCAHO.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Level of Risk</th>
<th>Area of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Low beds</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-slip grip footwear</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assign patient to bed that allows patient to exit toward stronger side</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lock movable transfer equipment prior to transfer</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individualize equipment to patient needs</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Why Look at Falls?  TJC Data on Falls

- Falls rate high on the list of sentinel events tracked by The Joint Commission (TJC)
- 4th leading cause of sentinel events now from 6th place
- June, 2013 data of 9,981 SE shows 586 falls which is about 6% of all sentinel events reported
  - 76 in 2012 and 96 in 2011 and 48 first 6 months 2013
- Other Joint Commission standards that are applicable to falls are in EC and PI chapters (PI.01.01.01 number of falls and number and severity of fall related injuries)
- TJC issues “Reduce your risk of falling” as one of their Speak UP brochures and video
Fall Related Events

Fall-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)

Sentinel Event Alert
#14: "Fatal Falls-Lessons for the Future" July 2000

Number of Events Reviewed by TJC

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<td>63</td>
<td>81</td>
<td>56</td>
<td>96</td>
<td>76</td>
<td>48</td>
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</table>
### TJC Root Causes of Falls

#### Root Cause Information for Fall-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)

<table>
<thead>
<tr>
<th>2004 through Jun 2013 (N=586)</th>
<th>The majority of events have multiple root causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>436</td>
</tr>
<tr>
<td>Leadership</td>
<td>335</td>
</tr>
<tr>
<td>Communication</td>
<td>329</td>
</tr>
<tr>
<td>Human Factors</td>
<td>323</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>219</td>
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<tr>
<td>Care Planning</td>
<td>125</td>
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<tr>
<td>Information Management</td>
<td>77</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>48</td>
</tr>
<tr>
<td>Special Interventions</td>
<td>42</td>
</tr>
<tr>
<td>Patient Education</td>
<td>41</td>
</tr>
</tbody>
</table>
www.jointcommission.org/PatientSafety/SpeakUp

Each year, millions of people are injured by falls. People at risk of falling include hospital patients, nursing home residents and those who are recovering from an illness or injury at home. This brochure includes tips and actions you can take to reduce your risk of falling, whether at home or in a medical facility.

The Joint Commission is the largest health care accrediting body in the United States that promotes quality and safety.

Helping health care organizations help patients

Reduce your risk of falling

SpeakUP™
Why do falls happen?
- Person is weak, tired or ill
- Person is not physically fit
- Person may have problems seeing
- Medicines may cause weakness, sleepiness, confusion or dizziness
- Slippery or wet floors or stairs
- Obstructed pathways
- Darkness

How to reduce your risk of falling

Take care of your health
- Exercise regularly. Exercise builds strength.
- Prevent dehydration. Dehydration can make it easier to lose your balance.
- Have your eyes checked. Make sure you do not have any eye problems or need a new prescription.
- Talk to your doctor if your medicine makes you sleepy, light-headed, sluggish or confused. Ask how to reduce these side effects or if you can take another medicine.

Take extra precautions
- Turn on the lights when you enter a room. Do not walk in the dark.
- Make sure your pathway is clear.
- Use the handrails on staircases.
- Sit in chairs that do not move and have arm rests to help when you sit down and stand up.
- Wear shoes that have firm, flat, non-slip soles. Do not wear shoes that do not have backs on them.
- Replace the rubber tips on canes and walkers when they become worn.

Make small changes to your home
- Install timers, “clap-on” or motion sensors on your lights.
- Use night lights in your bedroom, bathroom and the hallway leading to the bathroom.
- Keep the floor and stairs clear of objects such as books, tools, papers, shoes and clothing.
- Remove small area rugs and throw rugs that can slip. Rubber mats are a good replacement.
- Put frequently used items in easy-to-reach places that do not require using a step stool.
- Make sure your bed is easy to get in and out of.
- Apply non-slip treads on stairs.
- Apply non-slip decals or use a non-slip mat in the bathtub or shower.
- Install grab bars near the toilet and the bathtub or shower.

A home care agency, personal care and support agency, or community program may be able to help make changes to your home if you live alone and need help.

Take extra precautions in the hospital or nursing home
Many falls occur when patients or residents try to get out of bed either to go to the bathroom or walk around the room by themselves. If you need to get out of bed:
- Use your call button to ask for help getting out of bed if you feel unsteady.
- Ask for help going to the bathroom or walking around the room or in hallways.
- Wear non-slip socks or footwear.
- Lower the height of the bed and the side rails.
- Talk to your doctor if your medicine makes you sleepy, light-headed, sluggish or confused. Ask how to reduce these side effects or if you can take another medicine.

The goal of the Speak Up™ program is to help patients and their advocates become more informed and involved in their health care.
TJC Video on Reduce Risk of Falling

www.jointcommission.org/multimedia/speak-up-reduce-your-risk-of-falling/
The Joint Commission Matrix for Falls RCA

- TJC requires a RCA be done for reviewable sentinel events which includes a patient fall that results in death or major permanent loss of function as a direct result

- These are the elements that must be included in the RCA
  - So RCA must include area marked such as physical assessment process, individual observation process, medication management, staffing level etc.

- Available in SE 2013 policy (revised) at www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/
Root Cause Analysis Matrix
Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events – October 2005

Note: Updates are highlighted in **RED**
Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

<table>
<thead>
<tr>
<th>Behavioral assessment process (1)</th>
<th>Suicide (24 hr care)</th>
<th>Med. Error</th>
<th>Procedural Complication</th>
<th>Wrong site surgery</th>
<th>Treatment delay</th>
<th>Restraint death</th>
<th>Equipment death</th>
<th>Assault rape/ homicide</th>
<th>Transfusion death</th>
<th>Patient Abduction</th>
<th>Unanticipated death of full term infant</th>
<th>Unintended Retention of foreign body</th>
<th>Fall related</th>
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<tr>
<td>X</td>
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<td>Physical assessment process (2)</td>
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<td>Patient observation procedures</td>
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<tr>
<td>Care planning process</td>
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<td>X</td>
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<tr>
<td>Continuum of care</td>
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<td>X</td>
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<td>Staffing levels</td>
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<tr>
<td>Orientation &amp; training of staff</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Competency assessment/ credentialing</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Supervision of staff (3)</td>
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<td>X</td>
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<td>X</td>
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<td></td>
<td>X</td>
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<tr>
<td>Communication with patient/family</td>
<td></td>
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<td>X</td>
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<tr>
<td>Communication among staff members</td>
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<td>X</td>
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<tr>
<td>Availability of information</td>
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<td>X</td>
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<tr>
<td>Adequacy of technological support</td>
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<td>X</td>
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<tr>
<td>Equipment maintenance/ management</td>
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<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Physical environment (4)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Security systems and processes</td>
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<td>X</td>
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<tr>
<td>Medication Management (5)</td>
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</tr>
</tbody>
</table>
**Consider Doing a Falls FMEA**

**Failure Modes and Effects Analysis (FMEA) Tool**

<table>
<thead>
<tr>
<th>Outpatient falls risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Littleton Adventist Hospital</td>
</tr>
<tr>
<td>Littleton, Colorado, United States</td>
</tr>
<tr>
<td>Hospital-Community</td>
</tr>
</tbody>
</table>

**Aim:** To decrease outpatient falls by 50% in 12 months.

**Process Data**

Date: 03/30/2008

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Outpatient enters facility</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient check in at volunteer check-in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure Mode</th>
<th>Causes</th>
<th>Effects</th>
<th>Occ</th>
<th>Det</th>
<th>Sev</th>
<th>RPN</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers can not determine if patients are at risk to fall</td>
<td>No assessment tool or education for volunteers</td>
<td>No fall risk assigned to outpatients</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>450</td>
<td>Inact education on fall risk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>OP fills out registration form and volunteer signs the pt in for test/procedure</td>
</tr>
<tr>
<td>4</td>
<td>Patient sits in the waiting area and waits to be called by admissions</td>
</tr>
<tr>
<td>5</td>
<td>Admissions calls patient up to desk to obtain pt info</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure Mode</th>
<th>Causes</th>
<th>Effects</th>
<th>Occ</th>
<th>Det</th>
<th>Sev</th>
<th>RPN</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No info taken from patient</td>
<td>No tool or education to staff</td>
<td>Patients risk for falling</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>250</td>
<td>Inact falls risk tool and</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Admissions calls patient up to desk to obtain pt info</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure Mode</th>
<th>Causes</th>
<th>Effects</th>
<th>Occ</th>
<th>Det</th>
<th>Sev</th>
<th>RPN Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No info taken from patient specifically regarding falls risk</td>
<td>No tool or education to staff</td>
<td>Patients risk for falling unrecognized</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>250 Inact falls risk tool and education for staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Patient meets with admissions personal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure Mode</th>
<th>Causes</th>
<th>Effects</th>
<th>Occ</th>
<th>Det</th>
<th>Sev</th>
<th>RPN Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No assessment of falls risk</td>
<td>No tool for risk assessment; no staff training</td>
<td>All patients go unassessed</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>250 Inact a falls risk assessment and education of staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Patient leaves to designated testing area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure Mode</th>
<th>Causes</th>
<th>Effects</th>
<th>Occ</th>
<th>Det</th>
<th>Sev</th>
<th>RPN Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient not identified as a falls risk</td>
<td>No falls risk tool developed - no education of outpatient staff</td>
<td>High risk patients not identified as a falls potential</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>250 Inact falls risk assessment</td>
</tr>
</tbody>
</table>

### Calculated Totals

**Total Risk Priority Number for the process**: 1200

**Occ**: Likelihood of Occurrence (1-10)

**Det**: Likelihood of Detection (1-10)

**NOTE**:  
1 = Very likely it WILL be detected
10 = Very likely it WILL NOT be detected

**Sev**: Severity (1-10)

**RPN**: Risk Priority Number (Occ × Det × Sev)

### Annotation

None
CMS CoP Requirements

- CMS requires hospitals in the hospital CoPs to have a safe environment/setting
- CMS has this as hot spot in their Guidelines for Immediate Jeopardy
- CMS requires the health and safety of patients at risk are identified, investigated and resolved
- Having falls and no investigation would be a violation of this CoP which could come up during complaint or validation survey

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

New website

<table>
<thead>
<tr>
<th>App. No.</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Hospitals</td>
<td>2,185 KB</td>
</tr>
<tr>
<td>AA</td>
<td>Psychiatric Hospitals</td>
<td>606 KB</td>
</tr>
<tr>
<td>B</td>
<td>Home Health Agencies</td>
<td>761 KB</td>
</tr>
</tbody>
</table>
Why Look at Falls

- Falls program is the standard of care
- Substandard care could be the basis of a medical malpractice suit (average cost $70,000)
- Substandard care can be a compliance issue since billed for substandard care
  - Fraud and abuse issue with either CMS or the OIG
- In Autumn vs. CMS\(^1\) LTC found guilty and had to pay monetary penalty of $3,050 per day from the date of discovery of deficiency, until date of resurvey

\(^1\) Autumn Breeze Rehabilitation Center v. CMS, the Dept of HHS, No. CR1285, March 2005
Why Look at Falls

- CMS states that use of restraints for prevention of falls should not be considered a routine use of a fall prevention program (Tag 154)
- CMS states use of restraints does not reduce fall rate
- CMS states falls that occur when a patient is restrained often result in more serious injuries
- Articles were older publications
CMS Hospital CoPs

- Patient should not be restrained because he might fall (Tag 154)
- When assessing risk for falls consider if medical condition or symptom that indicates a current need for protective intervention
- History of falling without current clinical basis is inadequate
- Determine if there are other interventions that can be used to prevent the patient from falling
Why Look at Falls

- Falls are the leading cause of injury, hospitalization, and death for seniors (one third of adults over 65 each year, accessed CDC March 2014)

- 2.2 million treated in ED for injuries related to falls and CDC says 1.8 million (CDC¹)

- 581,000 seniors were hospitalized for fall injuries and 18,000 seniors died due to fall related injuries

- CDC issues two free publications²

¹ http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

² http://www.cdc.gov/ncipc/preventingfalls/
Falls Among Older Adults: An Overview

Each year, one in every three adults age 65 and older falls. Falls can cause moderate to severe injuries, such as hip fractures and head trauma, and can increase the risk of early death. Fortunately, falls are a public health problem that is largely preventable.

How big is the problem?

- One out of three older adults (those aged 65 or older) falls each year, but less than half talk to their healthcare providers about it.
- Among older adults, falls are the leading cause of both fatal and nonfatal injuries.
- In 2010, 2.3 million nonfatal fall injuries among older adults were treated in emergency departments and more than 662,000 of these patients were hospitalized.
- In 2010, the direct medical costs of falls, adjusted for inflation, was $30 billion.

What outcomes are linked to falls?

- Twenty to thirty percent of people who fall suffer moderate to severe injuries such as lacerations, hip fractures, or head trauma. These injuries can make it hard to get around or live independently, and increase the risk of early death.
- Falls are the most common cause of traumatic brain injuries (TBI).
- In 2000, 46% of fatal falls among older adults were due to TBI.
- Most fractures among older adults are caused by falls. The most common are fractures of the spine, hip, forearm, leg, ankle, pelvis, upper arm, and hand.
- Many people who fall, even if they are not injured, develop a fear of falling. This fear may cause them to limit their activities, which leads to reduced mobility and loss of physical fitness, and in turn increases their actual risk of falling.
Falls - Older Adults

We want a society where older adults can live safe, healthy and independent lives. While falls are a threat to the health and independence of older adults and can significantly limit their ability to remain self-sufficient, the opportunity to reduce falls among older adults has never been better. Today, there are proven interventions that can reduce falls and help older adults live better, and longer.

Get the Facts »

In the Spotlight

Publications and Resources
Older adult falls prevention guides for health care professionals, brochures, posters and more.

Related Resources

- Focus on Preventing Falls: A CDC Featured Topic
- Keeping Seniors Safe Podcasts
  - Listen (0:59) | (3:50)
- Concussion and Traumatic Brain Injury
- Elder Maltreatment
- HHS HealthBeat: The Shower Fall

Data & Statistics

Rate of Nonfatal, Medically Consulted Fall Injury Episodes, by Age Group

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1,000 population. Persons aged ≥75 years had the highest rate (115).

Graphic source: MMWR Quickstats, 02/03/2012

More data & statistics »
CDC Resources

- Has a fall prevention pocket guide for physicians published

- Fall risk perception and risk assessment project
  - Go to Stopfalls.org
  - Bibliography database updated
  - Focus is to help the community reduce falls in their homes

- Information that a community Tai Chi fall prevention program can help
Falls Brochures for Patients

Four things you can do to prevent falls:

1. Begin an exercise program to improve your leg strength & balance
2. Ask your doctor or pharmacist to review your medicines
3. Get annual eye check-ups & update your eyeglasses
4. Make your home safer by:
   - Removing clutter & tripping hazards
   - Putting railings on all stairs & adding grab bars in the bathroom
   - Having good lighting, especially on stairs

“People who use canes are brave. They can be more independent and enjoy their lives.”
Shirley Warner, age 79

“it’s not the broken hip, it’s the nursing home I don’t want. I need to be independent, so I take Tai Chi.”
Leonard Jones, age 74

www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html#download

Stay Independent
Falls are the main reason why older people lose their independence.

Are you at risk?

Contact your local community or senior center for information on exercise, fall prevention programs, or options for improving home safety.

For more information on fall prevention, please visit:
www.cdc.gov/injury
www.stopfalls.org

This brochure was produced in collaboration with the following organizations:

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
## Check Your Risk for Falling

<table>
<thead>
<tr>
<th>Statement</th>
<th>Why it matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (2) I have fallen in the past year.</td>
<td>People who have fallen once are likely to fall again.</td>
</tr>
<tr>
<td>Yes (2) I use or have been advised to use a cane or walker to get around safely.</td>
<td>People who have been advised to use a cane or walker may already be more likely to fall.</td>
</tr>
<tr>
<td>Yes (1) Sometimes I feel unsteady when I am walking.</td>
<td>Unsteadiness or needing support while walking are signs of poor balance.</td>
</tr>
<tr>
<td>Yes (1) I steady myself by holding onto furniture when walking at home.</td>
<td>This is also a sign of poor balance.</td>
</tr>
<tr>
<td>Yes (1) I am worried about falling.</td>
<td>People who are worried about falling are more likely to fall.</td>
</tr>
<tr>
<td>Yes (1) I need to push with my hands to stand up from a chair.</td>
<td>This is a sign of weak leg muscles, a major reason for falling.</td>
</tr>
<tr>
<td>Yes (1) I have some trouble stepping up onto a curb.</td>
<td>This is also a sign of weak leg muscles.</td>
</tr>
<tr>
<td>Yes (1) I often have to rush to the toilet.</td>
<td>Rushing to the bathroom, especially at night, increases your chance of falling.</td>
</tr>
<tr>
<td>Yes (1) I have lost some feeling in my feet.</td>
<td>Numbness in your feet can cause stumbles and lead to falls.</td>
</tr>
<tr>
<td>Yes (1) I take medicine that sometimes makes me feel light-headed or more tired than usual.</td>
<td>Side effects from medicines can sometimes increase your chance of falling.</td>
</tr>
<tr>
<td>Yes (1) I take medicine to help me sleep or improve my mood.</td>
<td>These medicines can sometimes increase your chance of falling.</td>
</tr>
<tr>
<td>Yes (1) I often feel sad or depressed.</td>
<td>Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.</td>
</tr>
</tbody>
</table>

Add up the number of points for each “yes” answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011;42(6):493-499). Adapted with permission of the authors.
Many falls can be prevented. By making some changes, you can lower your chances of falling.

**Four things YOU can do to prevent falls:**

1. Begin a regular exercise program
2. Have your health care provider review your medicines
3. Have your vision checked
4. Make your home safer

"We feel stronger when we walk frequently. And we have a more positive outlook."
Preventing Falls: What Works

A CDC Compendium of Effective Community-based Interventions from Around the World

Exercise-based Interventions

Home Modification Interventions

Multifaceted Interventions
Preventing Falls:
How to Develop Community-based
Fall Prevention Programs for Older Adults
STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Health Care Providers

Did you realize that one out of three people 65 and older falls each year? The good news is that health care providers can help reduce their patients’ chances of falling and of suffering serious injuries like hip fractures and traumatic brain damage.

CDC’s Injury Center created the STEADI Tool Kit for health care providers who see older adults in their practice who are at risk of falling or who may have fallen in the past. The STEADI Tool Kit gives health care providers the information and tools they need to assess and address their older patients’ fall risk.

Order Tool Kits

Print copies are currently out of stock. If you are interested in a future order if/when copies are available, please email us your name and address.

Download the STEADI Tool Kit materials

Download STEADI Tool Kit Materials

Make Fall Prevention Part of Your Practice

- **Triage Your Patients Based on Fall Risk**
  - This tool walks health care providers through assessing a patient’s fall risk, educating patients, selecting interventions, and following up.

- **Have Your Patients Check Their Risk of Falling**
  - This brochure offers a checklist that patients can use to check their risk of falling.

- **Prevent Falls in Older Patients, Provider Pocket Guide**
  - This small, easy-to-use tool walks health care providers through key points of fall prevention.

See Your Patient’s Risk at a Glance

- **This checklist allows health care providers to summarize an older patient’s fall risk.**

Integrate Fall Prevention into Your Practice

- **This wall chart helps health care providers determine who in their practice will be responsible for conducting fall risk assessments, delivering interventions, and providing education to older patients.**

Talk about Fall Prevention with Your Patients

- This document can help health care providers comfortably talk about fall prevention with

www.cdc.gov/homeandrecreationsafety/Falls/steadi/index.html
Preventing Falls in Older Adults

- Exercise regularly
- Have doctor or pharmacist review medications
- Get adequate calcium and Vitamin D in your diet
- Do a program of weight bearing exercises
- Get screened and treated for osteoporosis
- Have eyes checked annual and update your eyeglasses
- Reduce trip hazards in home, add grab bars and railing and improve lighting in your home
The Four C’s of Falls

- **Consistent** for all patients at risk for falling,
- **Cross Disciplines** means interdisciplinary approach,
- **Coordinated** from admission to discharge and continue at home,
- **Culture** from responding to errors to prevention from harm,
Introduction into Falls

- What are effective strategies or best practices for fall prevention?
- How can you reduce the fall rate in your facility?
- How can you decrease the level of injury or severity related to falls?
- Do you have a falls committee?
- How do you communicate risk factors for falls?
Introduction into Falls

- What patient and family education do you do?

- Remember you need a standardized assessment tool and injury risk assessment.

- How do you evaluate and monitor falls?

- How do you ensure accountability through auditing to make sure the falls risk assessments and interventions are done correctly?
Introduction into Falls

- What equipment and unit design configuration can maximize fall prevention?

- Standardize interventions for at risk patients with attention to highest risk patients

- Is there an understanding of the definition and any inconsistencies in reporting?
  - WHO said inconsistency in reporting and did not report coming to rest on the ground
  - WHO Global Report on Falls Prevention in Older Age. Available at: whqlibdoc.who.int/publications/2008/9789241563536_eng.pdf
Introduction into Falls

- What are common risks for falls?
- What is a good incident report specific for falls?
  - One study found 44% of falls were not captured on the hospital’s incident reporting system

- Falls assessment need to be patient specific and how do you use sitters for high risk patients

- How do you ensure compliance with risk assessments, incident investigations and confronting problem?
Introduction into Falls

- Preventing falls requires a **multifaceted fall prevention approach**
  - Fall prevention monitoring system
  - Creation of CNS position
  - Have a good policy and make sure staff educated on policy
  - Fall incident report, post fall assessment and documentation system
  - Individualized approach to fall prevention, PI, responsibility of all staff to prevent falls, etc.
Is There A Road Map to Preventing Falls?

Road Map to Preventing Falls

- Falls prevention program that includes:
  - A team approach
  - Identify what group is responsible to oversee the strategic plan for falls including planning, implementation and evaluation
    - **Unit based falls champions** (very important)
    - Look at unique needs of special population
  - Accurate and concurrent reporting
    - Need data on all falls
    - Need to analyze falls data for common factors and to make sure interventions are working
Road Map to Preventing Falls

- Expectations, Education, and Accountability
  - Clear expectations communicated to all including expectations on fall risk screening, assessment and interventions
  - Education for all clinical and non-clinical staff
  - Administration must provide resources and support for the falls program
  - Need to do continuing education for physicians and in new physician orientation
  - Annual training on fall prevention education
Fall Prevention Checks Include:

Fall prevention checks include:

2b) Check that bed alarms are in place and activated as appropriate.
2c) Patient beds are in the correct position.
2d) Ensuring safe pathways, e.g. reduced clutter, clear and well-lit pathway to bathroom, IV poles are in a safe position.
2e) Appropriate equipment and assistive devices, e.g. raised toilets with safety rails, commodes, shower chairs, floor mats are in use.
2f) Managers incorporate fall prevention checks during their observation audits and provide feedback to front-line staff on at least a quarterly basis.

3a) The facility has an algorithm in place to assign low-beds and floor mats to patients identified at high-risk for injury related to falls.
3b) Equipment to reduce risk for injury (e.g. low beds, hip protectors, floor mats) is accessible to staff.

4a) The facility has guidelines in place for appropriate bed alarm use, or alternatives to alarms (e.g. sitters), individualized to the patient’s risk factors.
4b) Forcing functions (e.g. alarm reset reminders on beds) or reminders (e.g. signage) are in place for resetting alarms prior to leaving patient’s room.
4c) Front-line staff from across the facility (e.g. therapy staff, nursing assistants) are trained on falls prevention equipment (e.g. bed alarms, chair alarms, low-bed use, floor mat placement).
It is important that you do not attempt to get out of bed or walk without assistance. We want to assist you when getting out of bed and walking to keep you safe from falling.

We will be in your room every hour to assist you with using the restroom, to make sure your call light is within reach, and to reposition you.

Remember call before you fall. It’s our job and it is not an inconvenience and we don’t want you to get hurt.
Definition of Falls

- One article reported that 21% of hospitals had not defined what constitutes a fall (ECRI, Oct. 2005),

- Reported also that only 82% of the facilities document in the chart the interventions chosen to mitigate the risk of falls,

- Documentation is important to provide the staff and hospital in the event a lawsuit is filed,
Definition of Falls

- Important to have a **definition** for falls and for staff to know what your definition is
- An unintended event resulting in a person coming to rest on the ground/floor or other lower level (witnessed)
- Or is reported to have landed on the floor (unwitnessed) not due to any intentional movement or extrinsic force such as stroke, fainting, seizure
- Basically an unplanned descent to the floor (NQF) or lower surface

Fall prevention in hospitals

Introduction and scope

Preventing falls among patients in a healthcare setting requires a multifaceted approach, and the recognition, evaluation and prevention of patient falls are significant challenges. Currently available research and data on fall prevention are from long-term care settings; however, much is applicable for all healthcare settings.

This Web site provides a summary of the issues, strategies and tools to define and measure falls, identify risks and target prevention strategies. Each fall prevention program is likely in a different stage of development, whether initiating a new program or expanding or improving an existing program.

www.premierinc.com/quality-safety/tools-services/safety/topics/falls/
Tool Kits for Fall Prevention

General fall prevention

CDC National Center for Injury Prevention and Control (NCIPC) - Tool kits
The Centers for Disease Control and Prevention, National Center for Injury Prevention and Control has current technical information and excellent materials about falls and fall-related injuries that can be used on an individual basis or incorporated into health promotion activities aimed at reducing falls among older adults.

CDC Tool kit to prevent senior falls
Includes the fact sheets, graphs and brochures about falls and fall prevention for older adults

Hill-ROM - Morse Instrument and fall scale
A comprehensive training program on the use of the Morse Instrument and Fall Scale has been made available through Hill-Rom. A copy can be requested by sending an email to safetyprograms@hill-rom.com.

Hill-ROM - Patient safety webinars
Free webinars for caregivers to achieve better outcomes, including No Falls, Clear Lungs (prevent VAP), and Safe Skin® Program. For more information, visit:

Hill-ROM Institute of Aging and Health website - Fall-Toolkit
Policies and Procedures

Fall Prevention/Intervention Strategies

The most common approach to fall prevention is the use of a program of multiple interventions that aims to minimize the patient's risk of falling. The following summarizes these interventions, representing best-available evidence based on expert opinion.

Assessment

Some form of assessment of a patient's risk of falling was utilized in most studies, particularly in the following situations:

- On admission to the hospital
- All confused and elderly before settling at night
- Post operative patients
- All elderly on prescribed analgesics, sedatives, anti-hypertensive, etc

Risk of Falling Diagnosis
Measurement

- How do you measure your fall rate?
- Difficult to benchmark data between facilities because definitions are different
- Also there are differences in the way facilities collect and report the data
- Problem of lack of risk adjustment
- One hospital sees twice as many elderly patients than the other hospital in town
Facility Falls Data Summary

CONFIDENTIAL DOCUMENT FOR QUALITY IMPROVEMENT ANALYSIS ONLY.
Data is not risk adjusted and should not be used to compare among facilities.

Facility __________________________ Month Ending ________________________

1. Total # of falls ................................................................. _______

2. Total # of falls with injury .................................................. _______

3. Total # of residents who fell ................................................ _______

4. Total # of residents with 2 or more falls................................. _______

5. Total # of falls per resident computed only for residents who fell:
   _____ divided by _____ = ....................................................... _______
   (Example: (total # of falls from #1 above) 14 Falls divided by (total # of residents who
   fell from #3 above) 10 residents = 1.4 Falls per residents who fell.)

6. For the month, total resident days:
   _____ x _____ = _______
   Average daily census multiplied by total days in the month = resident days.
   (Example: Average Daily Census 100 x 30 days = 3,000 Resident Days.)

7. Falls per 1,000 resident days:
   _____ x 1,000 = _______ divided by _____ = _______
   Total number of resident falls in one month from #1 above times 1,000, divided by
   total resident days from #6 above.
   (Example: 14 falls x 1,000 = 14,000 divided by 3,000 (total resident days) =
   4.66 falls per 1,000 Resident Days.)

8. Falls With Injury per 1,000 resident days:
   _____ x 1,000 = _______ divided by _____ = _______
   Total number of resident falls with injuries in one month from #2 above times 1,000,
   divided by total resident days from #6 above.
   (Example: 2 falls with injury x 1,000 = 2,000 divided by 3,000 (total resident days)
   = 0.66 falls with injury per 1,000 Resident Days.)

Note: For the purposes of this report “injury” means: any fracture, any sutures, any
need for hospitalization or other immediate medical attention, and any changes in
functional ability requiring a change in Care Plan. Injury does not include minor skin
tears or bruises.

HCANJ
Measurement

- Common method is to measure and track your fall rate using the following:

  - **Number of patient falls x 1,000**
    - Number of patient days

- Look at the total number of eligible falls and divide it by the total number of patient days,

- Then multiple this number by 1,000 to create a rate per 1,000 patient days,

- Can also look at patients at risk, patient who fell, or falls per bed

- Used by NQF at http://www.qualityforum.org/ and Maryland Quality Indicator Project at http://www.qiproject.org/
### Other Fall Rate Measurements

<table>
<thead>
<tr>
<th>The Number of Patients at Risk Rate</th>
<th>The Number of Patients Who Fell Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient falls ( x ) x 1,000</td>
<td>Number of patients who fell ( x ) x 1,000</td>
</tr>
<tr>
<td>Number of patients at risk</td>
<td>Number of patients at risk</td>
</tr>
</tbody>
</table>

- This rate is commonly used in long-term care facilities

- In this formula repeated falls experienced by the same person are only included once in the numerator
The Number of Falls per Bed

- Your facility had **4 falls** last month.
- Data shows you had **900** bed days last month,
- **Fall rate** = \( \frac{\text{number of falls}}{\text{bed days of care}} \times 1000 \)
  \[ \text{BDOC} = \left( \frac{4}{900} \right) \times 1000 = 4.44 \text{ per 1000 BDOC}, \]
- In other words for every 1000 bed days of care you can expect to have about 4 falls.
What is the Fall Rate?

- Studies show fall rate of acute care hospitals to be in range of 2.5% to 3.5%,
- Valuable to trend falls per 1,000 patient days,
- Difficult to compare from unit to unit not alone hospital to hospital unless risk adjusted,
- This means consideration of population mix and types of care,
- Some units and types of care will have higher falls than others (LTC, Neuro floor, Rehab),
What is the Fall Rate?

- Literature shows difficulty in comparing studies and trying to benchmark because studies use different calculations and some were not risk adjusted.

- Inpatient rate is between 1.7 to 25 falls per 1,000 patient days depending on care area with geropsych the highest (Currie 2008).
  - Morse shows fall rate as 2.2 to 7 per 1,000 bed days in acute care hospitals.
  - 11.0 to 24.9 percent in long term care.
  - 8.0 to 19.8 percent in rehabilitation hospitals.
  - 4 to 7.5 percent result in serious injury.
What is the Fall Rate Per 1000 Patient Days?

- Acute care first falls 2.2 (Magaziner et. al.)
- Neuro floor rate is 5.2
- Psychiatry at 4.1
- Rehab at 7.6 to 12.6
- Geriatrics at 7.8
- Medical surgical unit 3.6 falls (Donaldson)
Falls Injuries

- Falls are a nursing sensitive indicator
- Injuries are reported in 6-44% of acute inpatient falls
- Serious injury in 2 to 8% of falls (Currie, 2008) with less than 1% resulting in death
What is the Fall Rate?

- Some emergency department calculates by falls per 10,000 visits
- Other calculate falls per 1,000 visit
- Fall rate is 0.288 per 1,000 visit

Terrell, KN; Weaver CS; Giles, BK; Ross, MJ. (2008) ED Patient Falls and Resulting Injuries; Journal of Emergency Nursing. 35(2): 89-92
What is the Fall Rate?

- VHA, Inc. reported the fall rate as 3.0 per 1,000 patient days
- Maryland Quality Indicator Project reported fall rate as 3.7 per 1,000 patient days
- California Nursing Outcome Coalition reported 3.2 per 1,000 patient days
  - Updated report issued 2009
    www.calnec.org/globalPages/mainpage.aspx
- Falls is a nursing sensitive quality indicator See AHRQ study and Evidenced Based Handbook for Nurses
Bedside Floor Mat

- VA National Center for Patient Safety has a website on patient safety
- Includes a falls tool kit
- Tool kit has tips and tricks for selecting a floor mat with total of nine pages
- Also note blood thinner pamphlet for patients who fall and are on anticoagulants
- Go to http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html
Evidence Report/Technology Assessment
Number 151

Nurse Staffing and Quality of Patient Care

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
350 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. 290-02-0009

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http://www.ahrq.gov/clinic/tp/nursesttp.htm
Chapter 10. Fall and Injury Prevention

Leanne Currie

http://www.ahrq.gov/qual/nurseshdbk

Background

Fall and injury prevention continues to be a considerable challenge across the care continuum. In the United States, unintentional falls are the most common cause of nonfatal injuries for people older than 65 years. Up to 32 percent of community-dwelling individuals over the age of 65 fall each year, and females fall more frequently than males in this age group.\(^1\)\(^,\)\(^2\) Fall-related injuries are the most common cause of accidental death in those over the age of 65, resulting in approximately 41 fall-related deaths per 100,000 people per year. In general, injury and mortality rates rise dramatically for both males and females across the races after the age of 85, but males older than 85 are more likely to die from a fall than females.\(^2\)\(^,\)\(^6\) Unfortunately, fall-related death rates in the United States increased between 1999 and 2004, from 29 to 41 per 100,000 population.\(^2\)\(^,\)\(^7\) Sadly, these rates are moving away from the Healthy People 2010 fall-prevention goal, which specifically seeks to reduce the number of deaths resulting from falls among those age 65 or older from the 2003 baseline of 38 per 100,000 population to no more than 34 per 100,000.\(^8\) Thus, falls are a growing public health problem that needs to be addressed.

The sequelae from falls are costly. Fall-related injuries account for up to 15 percent of rehospitalizations in the first month after discharge from hospital.\(^9\) Based on data from 2000, total annual estimated costs were between $16 billion and $19 billion for nonfatal, fall-related injuries and approximately $170 million dollars for fall-related deaths across care settings in the community.\(^10\)\(^,\)\(^11\) Several factors have been implicated as causes of falls and injuries; to date,
Increase in nurse turnover increases the fall rate by 0.2%

ANA and NQF also have falls as a nursing sensitive or quality indicator

Also found adding one extra patient to LPN and nurse aide increased fall rate by 0.03

Found staffing in ICU was significant to the fall rate

Found lower falls rates with nurses satisfied with the care provided
Common Risk Factors for Falling

- History of falls, age over 80
- Arthritis and balance deficit
- Cognitive impairment, confusion, and depression (impaired mental status)
- Gait deficit and impaired ability to perform ADLs (unsteady gait)
  - Use of assistive device and muscle weakness
- Special toileting needs (lack of response time)
- Connected to O2, SCD boots, foley catheter etc.
Common Risk Factors for Falling

- Visual deficit (double risk) and fear of falling
- Cardiac arrhythmias and delirium
- Dizziness/lightheadedness and fatigue
- Fluid and electrolyte imbalance
- Multiple medications and orthostatic hypotension
- Longer LOS show increased risk and patients with bleeding disorders
Home Health Nurses

- Tinetti (1986) develop risk assessment for community dwellers with nine risk factors:
  - Mobility, morale, mental status
  - Distance vision
  - Hearing
  - Postural blood pressure
  - Back exam
  - Medication and ability to perform ADLs
Risk of Falling for Children

- Falls are relatively rare
- What’s in your policy and procedure for children?
- However Graf (2005) found risk factors to be
  - Seizure medication
  - Orthopedic diagnosis
  - IV
  - Physical/occupational therapy ordered
  - LOS (odds ratio 1.84 for every 5 days)

P&P for Children

- Uses many of the recommendations for adults
- Bed in low position with brakes on
- Keep night light on
- Orient patient and family to the setting
- Patients under 3 are placed in cribs
- If parent issues written release can go to junior bed
- If parent requests full bed must stay with child
- Non skid footwear if ambulating etc.
How-to Guide:
Reducing Patient Injuries from Falls

Transforming Care at the Bedside (TCAB) is a national effort of the Robert Wood Johnson Foundation and Institute for Healthcare Improvement designed to improve the quality and safety of patient care on medical and surgical units, to increase the vitality and retention of nurses, and to improve the effectiveness of the entire care team. For more information, go to http://www.ihi.org/ or http://www.rwjf.org/goto/tcabtoolkit.

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How to cite this document:
NURSING PROCEDURES MANUAL

FALLS PREVENTION PROGRAM (PEDIATRICS)

APPENDICES/ATTACHMENTS FOR THIS PROCEDURE

Appendix A: SNCP: Child Identified As at Risk for Falls
Appendix B: Use of the Soma Bed Enclosure

PURPOSE

To identify patients who are at risk for falling and to outline strategies used to develop patient specific or individualized plans of care to reduce inpatient falls and fall-related injuries. To involve the patient, family and caregiver in falls prevention through education.

CRITICAL POINTS

1. Safety Precautions are instituted on all patients, regardless if they have been identified as being at risk for falls or not.
2. Patients who have been identified as at risk for falls are placed on a Fall Prevention Program.
3. Patients are assessed for their falls risk on admission and every shift thereafter.
4. All Infants are placed on safety precautions. A falls risk assessment with the Pediatric Schmid Fall Score is not necessary in this population. However, once an infant begins to walk, then a falls risk assessment must be initiated and a fall prevention program started, if appropriate.

FALLS CATEGORIES

A. Anticipated physiological/intrinsic: patient diagnosis or characteristics that may predict patient’s likelihood of falling.

B. Unanticipated physiological/intrinsic: unpredictable if no previous history is present and no risk factors identified from assessment.
**NURSING PROCEDURES MANUAL**

**FALLS PREVENTION PROGRAM (PEDIATRICS) (continued)**

**APPENDIX A:** SNCP: (Patient Identified As at Risk for Falls)

[Click here to access online file]

<table>
<thead>
<tr>
<th>Initiated Date/Signature</th>
<th>Problem</th>
<th>Resolved Date/Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1Child Identified As at Risk for Falls</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related to:** Anticipated physiologic risk factors

**Expected Outcomes:** The patient will not fall.

1. Ensure that all safety precautions as noted in the Falls Prevention Program (Pediatrics) procedure are followed. *(Applies to ALL children regardless of Falls Score).*

**Nursing Interventions**

1. Place green dot on patient armband – Falls Precaution sign outside door.
2. Write in Kardex, "patient at risk for falls" and communicate this at each shift change.
3. Consider moving closer to the Nursing Station.
4. Staff alerted to make frequent visual checks.
5. Toileting schedule at least every 2 hours or more frequently if needed.
6. Commode at bedside.
7. Continuous supervision while toileting. Do not leave a patient who is at risk for falling unattended on a commode or in the bathroom.
8. Provide continuity of staff.
9. Obtain Physical Therapy and/or Occupational Therapy consult, i.e. for assistive device needs, as ordered.
10. Place in SOMA bed – as per Nursing Procedure: Fall Prevention Program (Pediatrics) Appendix C. Contact nursing supervisor or nurse manager to obtain bed.
11. Monitor lying and sitting BPs as condition warrants.
12. Family, friends to stay with patient, or sitter, if needed. Educate family and/or sitter regarding fall prevention.

**Comments (To add interventions after initial assessment, circle the number and make note here, e.g., “#6 Commode at bedside” added 3/2—due to frequent urination.”):**
# I’M SAFE Pediatric Fall Risk Assessment

<table>
<thead>
<tr>
<th>Fall Risk Score Criteria</th>
<th>Score if present</th>
<th>Score if not present</th>
<th>Patient’s Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment (I)</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Medications (M)</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sedation/anesthesia</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Admitting diagnosis (A)</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Fall History (F)</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Environment of care</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Fall Risk Score (total scores assigned for each criteria)**

**Interventions**
Interventions

a) Interventions to consider based on assessed risk (implement any appropriate interventions)
   i) Low risk interventions (Score 0)
      1. Hourly rounds/care checks (include assessment of elimination needs & re-orientation to call light)
      2. Patient/family education regarding fall prevention
      3. No activity/mobility restrictions necessary
      4. Bed to remain in low position
   ii) Moderate risk interventions (Score 1)
       1. Hourly rounds
       2. Provide & reinforce patient/family education regarding fall prevention
       3. Some assisting with activity/mobility per the patient’s individualized plan of care
       4. Educate patient/family to request help with ambulation
       5. Bed to remain in low position
   iii) High risk interventions (Score 2 or greater)
        1. Hourly rounds
        2. Assist patient with activity/mobility
        3. Ensure patient is placed in the appropriate bed (e.g., consider use of crib with topper “bubble top” for toddler)
        4. Yellow high fall risk band placed on patient
        5. Close observation, particularly when in a wheelchair or out of bed
        6. Assess need for 1:1
        7. Accompany patient with ambulation & transfers, especially when related to elimination needs
        8. Provide & reinforce patient/family education regarding fall prevention & include in the individualized plan of care
Pediatric Scoring

- Remember the goal is to eliminate all falls with injury though the fall prevention program and
- Goal to increase the percentage of patients who get an appropriate fall risk assessment and fall prevention intervention

Risk Score
- Low risk = 0 (all peds patients are, at a minimum, a low fall risk)
- Moderate risk = 1
- High risk = 2 or greater
  - Patients age 2 years & younger are scored as high risk
  - Patients admitted to the ICU are scored as high risk
# Don’t Forget OB Patient Fall Risks

<table>
<thead>
<tr>
<th>Category:</th>
<th>Patient Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Fall Prevention</td>
</tr>
<tr>
<td>Purpose:</td>
<td>To define process and procedures related to fall prevention within the Perinatal Services department.</td>
</tr>
<tr>
<td>Policy:</td>
<td>See entity policy and procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure: I: Assessment, Reassessment, and Plan of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upon admission, complete the Hendrich II Fall Risk assessment</td>
</tr>
<tr>
<td>2. Make referrals to other disciplines based on pre-identified scoring parameters found on the assessment.</td>
</tr>
<tr>
<td>3. For all patients identified at risk, complete an individualized plan of care.</td>
</tr>
<tr>
<td>4. OB patients are not reassessed after the initial admission process.</td>
</tr>
<tr>
<td>5. Ensure that patients with an epidural catheter remain on bedrest and assist with repositioning.</td>
</tr>
<tr>
<td>6. Assist the post delivery patient to the bathroom for the first time and remain with the patient during toileting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure: II. Patient and Family Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Instruct the patient regarding risk factors present during the period of administration/recovery from spinal/epidural anesthesia and post vaginal delivery</td>
</tr>
</tbody>
</table>
Medications

- Risk is greater if patient is taking four or more types of medications
- Over the counter medication can also increase the risk of falling
- 21% of falls from recent study were involving patients taking one or more medications that influence fall rate
- Patients at risk for serious injury include those on anticoagulants (also over age 85, with prolonged steroid use, bone conditions such as osteoporosis or metastatic bone cancer)
Medications

- Half of falls due to medications like antianxiety and antipsychotics (ICSI, 2012)

Medications most frequently associated with increased risk of falling

- Serotonin-reuptake inhibitors
- Tricyclic antidepressants
- Neuroleptic agents
- Benzodiazepines
- Anticonvulsants
- Class IA antiarrhythmic medications
Medications

- Anti-hypertensive
- Diuretics
- Laxatives and patient undergoing prep for colonoscopies and other similar tests
- Nonsteroidal anti-inflammatory agents
- Psychotropics
- Sedatives and hypnotics
- Vasodilators
Fall Risk Medication Component

- One hospital added one with four risk categories of risk for medications and category 4 marked with orange sticker

- **Risk Category 1** includes anti-depressant and anti-psychotics and focuses on dosage adjustment made in past five days,

- **Risk Category 2** includes bowel prep and diuretics since these can lead to electrolyte imbalance, hypotension, and urgency related to the need to eliminate
Fall Risk Medication Component

- **Risk Category 3** included opiates, narcotics, analgesics and antihistamines since these can lead to sedation, depressed reflexes, and can effect motor coordination.

- **Risk Category 4** includes Benzodiazepines and Alpha Blockers, which can be associated with sedation, dizziness, balance control, and hypotension.

- Also note Beers List is medications that should not be given to the elderly as can increase the fall rate and AHRQ as a toolkit.
### BEERS CRITERIA


The following medications should be avoided or used very cautiously in persons aged 65 years and over, independent of their health conditions and diagnoses.

<table>
<thead>
<tr>
<th>Drug Name or Class</th>
<th>Comments</th>
<th>Severity (High or Low)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long-acting benzodiazepines:</strong></td>
<td>These agents have very long half-lives, cause prolonged sedation and increase the risk of falls and fractures.</td>
<td>High</td>
</tr>
<tr>
<td>Chloridiazepoxide (alone or in combination Librium, Librax, Limbitrol)</td>
<td>If benzodiazepine therapy is unavoidable, use short-acting agents.</td>
<td></td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quazepam (Doral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Halazepam (Paxipam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clorazepate (Trancene)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluazepam (Dalmane)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-acting benzodiazepines should rarely exceed the doses shown below:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (Ativan) 3mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxazepam (Serax) 60mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triazolam (Halcion) 0.25mg</td>
<td>With rare exceptions, the agents should be used only in persons who are physically dependent or who are being treated with short-course therapy for an acute condition.</td>
<td>High</td>
</tr>
<tr>
<td>Alprazolam (Xanax) 2mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temazepam (Restoril) 1.5mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meprobamate (Miltown and Equanil)</td>
<td>This amniotic is highly sedating and addictive. All use should be avoided except in individuals who are already physically dependent.</td>
<td>High</td>
</tr>
<tr>
<td>Barbitalates except Phenobarbital for seizures</td>
<td>All use should be avoided except in individuals who are physically dependent or for seizure disorder management. There are safer sedative-hypnotics available.</td>
<td>High</td>
</tr>
<tr>
<td>Amantadine (Elavil), chloridiazepoxide-amantadine (Limbitrol), Amantadine-pentazocine (Triavil), doxepin (Sinequan)</td>
<td>Amantadine and doxepin are very sedating and anticholinergic, their use should be avoided.</td>
<td>High</td>
</tr>
<tr>
<td>Methylphenidate (Ritalin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methyldopa (Aldomet)</td>
<td>All use should be avoided. Methyldopa causes bradycardia and can exacerbate depression in the elderly. Safer antihypertensives are available.</td>
<td>High</td>
</tr>
<tr>
<td>Methyldopa-hydrochlorothiazide (Aldoril)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserpine at doses ≥ 0.25mg</td>
<td>All use should be avoided. Safer antihypertensives are available.</td>
<td>Low</td>
</tr>
<tr>
<td>Indomethacin (Indocin and Indocin SR)</td>
<td>All use should be avoided. Other NSAIDs cause CNS toxic reactions less often.</td>
<td>High</td>
</tr>
<tr>
<td>Chlorpropamide (Diabinese)</td>
<td>All use should be avoided. Other oral hypoglycemics have shorter half-lives and do not cause SIADH.</td>
<td>High</td>
</tr>
<tr>
<td>Propantheline (Darvon) and combination products (Darvon-N, Darvon-N, Darvon with ASA)</td>
<td>All use should be avoided; it has little advantage over acetaminophen. Other analgesics are safer and more effective.</td>
<td>Low</td>
</tr>
<tr>
<td>Pantoprazole (Talwin)</td>
<td>All use should be avoided. Other narcotics are more effective and safer.</td>
<td>High</td>
</tr>
<tr>
<td>Ergot Mesylate (Hydergine) and Cyclophosphamide</td>
<td>All use should be avoided. Have not been shown effective in the doses studied.</td>
<td>Low</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>Use only in the smallest effective dose and only for emergency treatment of allergic reactions. Causes confusion and sedation.</td>
<td>High</td>
</tr>
</tbody>
</table>
# PHARMACIST
## FALL RISK ASSESSMENT INSTRUMENT

**Patient:**

**Date:**

**Admission Date:**

**Doctor:**

Circle appropriate numbers in each section

### SECTION I: HISTORY OF FALLS:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to two falls in a month/quarter</td>
<td>2</td>
</tr>
<tr>
<td>More than two falls in a month/quarter</td>
<td>8</td>
</tr>
<tr>
<td>Fall-related fracture (date):</td>
<td>5</td>
</tr>
<tr>
<td>Postural hypotension (orthostasis)</td>
<td>1</td>
</tr>
<tr>
<td>Syncope/dizziness</td>
<td>1</td>
</tr>
<tr>
<td>Unsteady or shuffling gait</td>
<td>2</td>
</tr>
</tbody>
</table>

SECTION I SUB-TOTAL: ____

### SECTION II: MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>1</td>
</tr>
<tr>
<td>NSAID</td>
<td>1</td>
</tr>
<tr>
<td>Antihypertensive</td>
<td>1</td>
</tr>
<tr>
<td>Narcotic analgesic:</td>
<td></td>
</tr>
<tr>
<td>Diuretic</td>
<td>1</td>
</tr>
<tr>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Hypnotic</td>
<td>2</td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td></td>
</tr>
<tr>
<td>Sedating antidepressant or antihistamine</td>
<td>2</td>
</tr>
<tr>
<td>Hypoglycemic</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>2</td>
</tr>
</tbody>
</table>

SECTION II SUB-TOTAL: ____

### SECTION III: DISEASE

<table>
<thead>
<tr>
<th>Incontinence</th>
<th>Cardiac</th>
<th>Neurologic/Psychiatric</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel</td>
<td>2</td>
<td>Arrhythmia</td>
<td>1</td>
</tr>
<tr>
<td>Bladder</td>
<td>2</td>
<td>CHF</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION III SUB-TOTAL: ____

Risk Factor: Minimal 0-2, Moderate 3-6, High-risk 7 or more

TOTAL: ____
Causes of Falls

- Falls can be classified in a number of ways
- Can be based on environmental or physiological
- One approach used by Janet Morse is to classify as
  - Accidental, unanticipated physiologic, or anticipated physiologic
- Prevention depends on the type of fall
Morse - 3 Classifications of Falls

- **Accidental** – a fall can occur in a low risk patient due to an environmental hazard such as the patient slipping or tripping, such as water on the floor so to prevent reduce environmental hazard (14%)

- **Anticipated physiological**- falls by persons considered to be at risk for falling (8%)
  - The patients have some risk factors for falling such as abnormal gait, frequent toileting needs, high risk medications, etc.
  - Close supervision and attempt to address risk factors

- **Unanticipated physiological** - falls attributed to physiological factors that can not be predicted before the first fall (78%)
  - Such as a stroke, seizure, or syncopal episode so need appropriate post fall care
Intrinsic vs. Extrinsic Factors

- Generally accepted that falls are caused by multiple factors

- Another classification scheme is that falls result from complex interaction of extrinsic and/or intrinsic factors

- **Intrinsic** is related to patient’s physical, mental and cognitive condition

- **Extrinsic** is related to the environment

Source: Tideiksaar, 1998
Risk Factors for Falls

Research has identified many risk factors that contribute to falling—some of these are modifiable.

Most falls are caused by the interaction of multiple risk factors. The more risk factors a person has, the greater their chances of falling. Healthcare providers can lower a person’s risk by reducing or minimizing that individual’s risk factors.

To prevent falls, providers should focus FIRST on these modifiable risk factors:

- Lower body weakness
- Difficulties with gait and balance
- Use of psychoactive medications
- Postural dizziness
- Poor vision
- Problems with feet and/or shoes
- Home hazards

Fall risk factors are categorized as intrinsic or extrinsic.

<table>
<thead>
<tr>
<th>Intrinsic</th>
<th>Extrinsic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced age</td>
<td>Lack of stair handrails</td>
</tr>
<tr>
<td>Previous falls</td>
<td>Poor stair design</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>Lack of bathroom grab bars</td>
</tr>
<tr>
<td>Gait &amp; balance problems</td>
<td>Dim lighting or glare</td>
</tr>
<tr>
<td>Poor vision</td>
<td>Obstacles &amp; tripping hazards</td>
</tr>
<tr>
<td>Postural hypotension</td>
<td>Slippery or uneven surfaces</td>
</tr>
<tr>
<td>Chronic conditions including arthritis, diabetes, stroke, Parkinson’s,</td>
<td>Psychoactive medications</td>
</tr>
<tr>
<td>incontinence, dementia</td>
<td>Improper use of assistive device</td>
</tr>
<tr>
<td>Fear of falling</td>
<td></td>
</tr>
</tbody>
</table>

www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html#download
Intrinsic Risk Factors

These are integral to patient’s system and many are associated with age-related changes

- **Previous fall** - studies have cited a history of falls as a significant factor associated with patients being more likely to fall again

- **Reduced vision or visual acuity** – vision affected by, for example, a decline in visual acuity, decreased night vision, altered depth perception, decline in peripheral vision, or glare intolerance

- **Unsteady gait** - manner and style of walking
Intrinsic Risk Factors

- Mental status – status affected by confusion, disorientation, inability to understand, and impaired memory, dementia, depression, poor impulse control, inability to perceive depth

- Having had a stroke in the past with sustained neurological impairment

- Low physical activity, being given a laxative or psychotropic drug, or sedative

- Acute illnesses – rapid onset of symptoms associated with seizures, stroke, orthostatic hypotension, and febrile conditions
Intrinsic Risk Factors

- Chronic illnesses - conditions such as arthritis, cataracts, glaucoma, dementia, diabetes and Parkinsonism
- Postural or orthostatic hypotension
- Incontinence or urinary frequency or urgency
- Use of four or more prescriptions
- Belief that asking for help is inappropriate - call before you fall campaign and age
- Fear of falling that increases the fall rate after increased mobility
Extrinsic Risk Factors

External to the system and relating to physical environment

- **Medications** - those that affect the central nervous system, such as sedatives and tranquilizers, benzodiazepines, and the number of administered drugs (some consider intrinsic)

- **Bathtubs and toilets** – equipment without support, such as grab bars, toilets in low position

- **Design of furnishings** – height of chairs and beds, bed in high position, table or beds that are on wheels and have sharp edges
Extrinsic Risk Factors

- **Condition of ground surfaces** - floor coverings with loose or thick-pile carpeting or throw rug, sliding rugs, upended linoleum or tile flooring, highly polished or wet floors

- **Poor illumination conditions** - intensity or glare issues and monochromatic color schemes or colors that agitate

- Distracting noise and prolonged length of stay

- Use of restraints
Extrinsic Risk Factors

- Poor staff training
- Not answering call lights promptly
- Attached to equipment like monitor or IV or oxygen tubing
- Time of day (more falls at night)
- ECT therapy in behavioral health
- Being physically challenged in rehab
# Environment Assessment to Prevent Falls

## PATIENT ROOM

<table>
<thead>
<tr>
<th>Item #</th>
<th>Environmental Consideration</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Room # / area deficiencies found</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there adequate lighting in the patient’s room? (Bright light – no burned out bulbs?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the nightlight on the patient’s bed functional / operating?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does the patient have an unobstructed path to the bathroom?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Are patient room furnishings safely arranged?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is bedside furniture free of sharp edges?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Is the bedside furniture sturdy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are beds / stretchers kept at lowest setting whenever possible?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Are beds / stretchers kept in locked position?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Were the upper siderails in the up position for patient to reach controls?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Was the bedcheck system on in the patient’s room?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Were the patient’s personal belongings / telephone call bell within reach?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Are handrails provided in patient bathroom and properly secured?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Emergency call button / cord in patient care bathroom present and works properly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are nonslip surfaces provided in patient showers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Are the door openings into the patient bathroom wide enough for an assistive device to fit through?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Are door openings flush with the floor for ease of movement for patient equipment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## EQUIPMENT

<table>
<thead>
<tr>
<th>Item #</th>
<th>Environmental Consideration</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Portable equipment pushed by patient (i.e. IV pole) sturdy and in good repair?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Are bedside commodes available on the unit and have proper rubber slip tips on the legs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Do walkers / canes / crutches have the appropriate slip tips?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Are wheelchairs locked when stationary?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Is broken equipment properly tagged for non-use?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Other Environmental Considerations

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Are floor surfaces/carpets free of cracks and tripping hazards?</td>
</tr>
<tr>
<td>23</td>
<td>Are hallways kept adequately clear/clutter free to allow patient ambulation?</td>
</tr>
<tr>
<td>24</td>
<td>Are floors properly marked when wet to avoid slipping or spill cleaned up immediately?</td>
</tr>
<tr>
<td>25</td>
<td>Do parking lots have uneven pavement/potholes/tripping hazards?</td>
</tr>
<tr>
<td>26</td>
<td>Do sidewalks have uneven pavement/tripping hazards?</td>
</tr>
<tr>
<td>27</td>
<td>Entrance areas free and clear?</td>
</tr>
<tr>
<td>28</td>
<td>Parking areas/entrances well-lit?</td>
</tr>
<tr>
<td>29</td>
<td>Parking lots well marked?</td>
</tr>
</tbody>
</table>
Interventions Universal Fall Precautions

Identify steps and interventions to prevent falls in light of the intrinsic and extrinsic factors and the score on the risk assessment:

- Bed in low position
- Toileting and continence programs
  - Elevated toilet seats
- An appropriate armchair with wheels locked at the patient’s bedside
Interventions Universal Fall Precautions

- Comprehensive patient assessment and environmental assessment
- Assess for low BMI, osteoporosis, vitamin D deficiency and anti-platelet therapy since evidence based practice recommendations
- Ensure that the pathway to the restroom is free of obstacles and properly lighted
- Sturdy handrails in patient bathrooms
- Ensure the hallways are clear of obstacles
  - Top TJC Problematic Standard
Interventions Universal Fall Precautions

- Bathroom close to bed or bedside commode
  - Do not leave patient unattended in bathroom
- Medication review
  - Reconciliation of medication should also be done
  - Treat underlying disorders such as syncope, diabetes and anemia
- Increase mobility and get patients moving
- Instruct the patient or resident to request assistance as needed - call before you fall
- Safe handling practices
Interventions

- Answer call lights promptly and one hour rounds during day and evening on high risk patients
  - Use teach back regarding call light use
  - Have patient demonstrate call light
- Instruct the patient to wear non-skid footwear
- Place assistive devices such as walkers and canes within a patient’s or resident’s reach
- Evaluate chair and bed height, lower bedrails
- Validate instrument that assesses for risk injury
- Reassess at regular intervals
Interventions

- Consider peak effect for prescribed medications that affect level of consciousness, gait and elimination when planning patient care

- Reduce use of **restraints**

- Observe environment for potentially unsafe conditions, such as loose carpeting and water on the floor. Do not over wax. Notify appropriate department(s) of hazardous conditions

- Use alarm devices

- Monitor and treat calcium and Vit D deficiencies for long term care patients
Interventions

- Do not leave “at risk” patients or residents unattended in diagnostic or treatment areas such as x-ray
- Ensure patients or residents being transported by stretcher/bed have all side-rails in the up position during transport and while awaiting test
- Reduce bedrail hazards
- Use floor mats
- Keep patient’s personal items within reach at all times
- Transfer belts should be available
- Assess need for 1:1 monitoring
Plan of Care

- Interventions are also based on the actual number obtained on the risk assessment tool.

- Morse scale, Hendrich II, Tinetti, Schmidt, John Hopkins, STRATIFY, Downton, Innes, or other evidenced based scales.

- Recent history of falls (category) and indicator is fallen past 3 months gives you 7 points.

- North America Nursing Diagnosis Association nursing diagnosis guideline on “risk for falls”
Plan of Care Based on Total Score

- Poor mobility/generalized weakness (category) and indicator is difficulty rising from chair unassisted, unsteady gait, use of assistive devices, needs assistance, imbalance gives you 4 points

- Altered elimination and indicator is incontinence, frequency, nocturia, diarrhea, needs assist toileting, gives you 3 points

- Confusion/disorientation and indicator is poor judgment, lack of safety awareness, not able to follow instructions and memory problems gives you a score of 3
Plan of Care

- Dizziness/vertigo/syncope and indicator is related medications, blood/volume loss, vital signs INR, orthostatic changes, dizzy with position change gives you score of 3 points

- Medications and indicator is psychotropics, antihistamine, benzodiazepines, antidepressants, cardiac-hypertensive meds, diuretics, laxatives, multiple meds, sleep aides gives you a 3 points
Plan of Care

- Poor judgment (if not confused) and indicator is lacks safety awareness, needs assistance but reports independence gives you score of 3 points

- Eye sight and indicator is decreased vision, nonuse of optical devices gives score of 2

- Age and indicator is over 65 years of age and gives you score of 1
# FALL RISK ASSESSMENT

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>SCORE</th>
<th>RESIDENT STATUS/CONDITION</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Level of Consciousness/</td>
<td>0</td>
<td>ALERT—(oriented x 3) or COMA TOS 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td>2</td>
<td>DISORIENTED x 3 at all times</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>INTERMITTENT CONFUSION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B History of Falls</td>
<td>0</td>
<td>NO FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(past 3 months)</td>
<td>2</td>
<td>1-2 FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3 OR MORE FALLS in past 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Ambulatory Elimination</td>
<td>0</td>
<td>AMBULATORY / CONTINENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td>2</td>
<td>CHAIR BOUND—may require restraints/assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>AMBULATORY / INCONTINENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Vision Status</td>
<td>0</td>
<td>ADEQUATE (with or without glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>POOR (with or without glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>LEGALLY BLIND</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Gait / Balance</td>
<td>0</td>
<td>GAIT/BALANCE normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If total is greater than 1</td>
<td>1</td>
<td>Balance problem while standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— refer to Rehab Department</td>
<td>1</td>
<td>Balance problem while walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for screening</td>
<td>1</td>
<td>Decreased muscular coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Change in gait pattern when walking through</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>doorway</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Jerking or unstable when making turns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Requires use of assistive devices (i.e., cane,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Wc, walker, furniture)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Systolic Blood</td>
<td>0</td>
<td>NO NOTED DROP between lying and standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure</td>
<td>2</td>
<td>Drop LESS THAN 20mm Hg between lying and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Drop MORE THAN 20mm Hg between lying and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Medications</td>
<td>0</td>
<td>NONE of these medications taken currently or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>TAKES 1-2 of these medications currently and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>TAKES 3-4 of these medications currently and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or/and within last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>If resident has had a change in medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and/or change in dosage in the past 5 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>— score 1 additional point</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Predisposing Diseases</td>
<td>0</td>
<td>NONE PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1-2 PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3 OR MORE PRESENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:** Assess the resident status in the right clinical condition parameters listed below (A-H) by assigning the corresponding score that best describes the resident's status in the appropriate assessment column. Add the column of numbers to obtain the Total Score. If the total score is 15 or greater, the resident may be considered at HIGH RISK for falls. An intervention protocol should be initiated immediately and documented on the care plan.

**NOTE:** Total score above 10 may represent HIGH RISK

---

**TOTAL SCORES**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>SIGNATURE / TITLE</th>
<th>DATE</th>
<th>Assessment</th>
<th>SIGNATURE / TITLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>/</td>
<td>2.</td>
<td></td>
<td>/</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>/</td>
<td>3.</td>
<td></td>
<td>/</td>
</tr>
</tbody>
</table>

**RESIDENT NAME:** Last, First, Middle Initial Chart #: __________
Level 1  Score 0-3

- Intervention is based on score
- All patients get level one
- Orient to environment and patient items, call light within reach
- Bed low and locked
- Night light evening and night shift
- Non-slip footwear, use of visual / hearing devices,
- Safest rail position for mobility (3 or less rails up)
- Room, floor free of obstacles and educate pt /family related fall risk factors/ prevention strategy
Level 2 Score 4-7

- Patients get everything in level 1 plus the following
- Fall Precaution ID band, magnet, red or yellow socks, different colored gown, and on Kardex
- Toilet before bedtime & q 4 hr. while awake
  - Do not leave unattended in bathroom. Bedside commode prn
- Observe Q 2 hr. day for care needs/obstacles
- Observe for orthostatic symptoms with activity
- Increase daytime activity to increase rest at night
Level 2 Score 4-7

- Communicate fall risk in report & when sending to other departments
- Cannot be unattended when transported
- Use gait belt and assist devices as appropriate
- PT/OT screen with new onset of poor mobility
- Transport on cart to procedures (to facilitate transfers)
Level 3 Score 8 or More

- Get everything in level 1 and 2 plus the following
- Observe every 1 hr. for care needs/obstacles
- Relocate for improved visibility
- Supervise patient when toileting, ambulating or transferring
- Obtain high-low bed and keep in low position when unattended
  - See safe room set up
- Encourage family to stay with patient or sitter
- Bed or chair alarm
Bed trapeze
Falls prevention poster
Non-exit side rails up for support
Exit side head rail up for support and foot rail down at all times.
Movable hand rail (Hemi-walker) always within reach
Bedside commode placed alongside bed (replaces urinal)
Non-skid floor
Room illuminated at all times
Bed controls at fingertips
Bed alarm
Bedside commode placed alongside bed (replaces urinal)
Non-skid floor
Room illuminated at all times
Non-slip floor mat absorbs fluids, food, & stool, and prevents slips
<table>
<thead>
<tr>
<th>Variable</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18-30</td>
<td>31-60</td>
<td>61-75</td>
<td>&gt;75</td>
</tr>
<tr>
<td>History of Falls</td>
<td>No history</td>
<td>&gt; 6 months</td>
<td>1-6 months ago</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Alert &amp; Oriented x 3, follows instructions</td>
<td>Oriented to person/place</td>
<td>Oriented to person only, Short Term Memory loss</td>
<td>Disoriented, unable to follow instructions</td>
</tr>
</tbody>
</table>
## Ambulatory Outpatient Fall Assessment

9 or more points patient at risk of fall

<table>
<thead>
<tr>
<th>Physical Mobility</th>
<th>No physical impairment, no assistive devices to ambulate</th>
<th>Use assistive device and/or able to ambulate</th>
<th>Assist of 2 or more to ambulate</th>
<th>Unable to ambulate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication/Sensory Impairment</strong>&lt;br&gt;(vision, hearing, speech, neuropathy, language barrier)</td>
<td>No deficits</td>
<td>1 deficit with correction</td>
<td>1 deficit without correction or 2 deficits with correction</td>
<td>3 or more deficits or onset of 1 new problem</td>
</tr>
<tr>
<td><strong>Elimination</strong>&lt;br&gt;(nocturia, frequency, urgency, diarrhea, incontinence, retention, laxative, bowel prep)</td>
<td>No problem</td>
<td>1 problem and/or Foley/ostomy</td>
<td>2 problems or removal of Foley within 24 hours</td>
<td>3 or more problems or onset of 1 new problem</td>
</tr>
</tbody>
</table>
The “Get Up and Go Test” is an assessment that should be conducted as part of a routine evaluation when dealing with older persons. Its purpose is to detect “fallers” and to identify those who need evaluation.

The staff should be trained to perform the “Get Up and Go Test” at check-in and query those with gait or balance problems for falls.

**INITIAL CHECK**

All older persons who report a single fall should be observed as they:

- From a sitting position, stand without using their arms for support.
- Walk 10 feet, turn, and return to the chair.
- Sit back in the chair without using their arms for support.

Individuals who have difficulty completing the above in less than 10 seconds or demonstrate unsteadiness performing this test require further assessment.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Level of Risk</th>
<th>Area of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Low beds</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-slip grip footwear</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assign patient to bed that allows patient to exit toward stronger side</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lock movable transfer equipment prior to transfer</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individualize equipment to patient needs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>High risk</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-skid floor mat</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medication review</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Exercise program</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Toileting worksheet</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Color armband / Falling Star etc</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Perimeter mattress</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hip protectors</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bed/chair alarms</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
**Stratify Risk Assessment Tool**

Answer all five questions below and count the number of “Yes” answers.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the patient present to hospital with a fall or has he or she fallen on the ward since admission (recent history of fall)?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is the patient agitated?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is the patient visually impaired to the extent that everyday function is affected?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is the patient in need of especially frequent toileting?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Does the patient have a combined transfer and mobility score of 3 or 4? (calculate below)</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*Transfer score:* Choose one of the following options which best describes the patient’s level of capability when transferring from a bed to a chair:

- 0 = Unable
- 1 = Needs major help
- 2 = Needs minor help
- 3 = Independent

*Mobility score:* Choose one of the following options which best describes the patient’s level of mobility:

- 0 = Immobile
- 1 = Independent with the aid of a wheelchair
- 2 = Uses walking aid or help of one person
- 3 = Independent

**Combined score** (transfer + mobility):

Total score from questions 1-5: __________

0 = Low risk
1 = Moderate risk
2 or above = High risk
# Supplement Tools with Medication Risk

## Medication Fall Risk Score

<table>
<thead>
<tr>
<th>Point Value (Risk Level)</th>
<th>American Hospital Formulary Service Class</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (High)</td>
<td>Analgesics,* antipsychotics, anticonvulsants, benzodiazepines†</td>
<td>Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition</td>
</tr>
<tr>
<td>2 (Medium)</td>
<td>Antihypertensives, cardiac drugs, antiarrhythmics, antidepressants</td>
<td>Induced orthostasis, impaired cerebral perfusion, poor health status</td>
</tr>
<tr>
<td>1 (Low)</td>
<td>Diuretics</td>
<td>Increased ambulation, induced orthostasis</td>
</tr>
<tr>
<td>Score ≥ 6</td>
<td></td>
<td>Higher risk for fall; evaluate patient</td>
</tr>
</tbody>
</table>

* Includes opiates.
† Although not included in the original scoring system, the falls toolkit team recommends that you include non-benzodiazepine sedative-hypnotic drugs (e.g., zolpidem) in this category.

## Medication Fall Risk Evaluation Tools

Use the tools below when evaluating patients found to have high medication-related risk for falls. The comments section provides information on how to evaluate the indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>Beers criteria,* dose adjustment for renal function or disease state, overuse of medications, IV access</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Therapeutic drug levels (digoxin, phenytoin), international normalized ratio, electrolytes, hemoglobin/hematocrit</td>
</tr>
<tr>
<td>Disease states</td>
<td>Comorbidities, hypertension, congestive heart failure, diabetes, orthopedic surgery, prior fall, dementia, other†</td>
</tr>
<tr>
<td>Education</td>
<td>Patient’s ability/willingness to learn, patient’s mental status</td>
</tr>
</tbody>
</table>

† Age 65 years or older.
# Hendrich II Falls Risk Model

## RISK FACTOR ASSESSMENT

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion/disorientation</td>
<td>4</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
</tr>
<tr>
<td>Altered elimination (incontinence, nocturia, frequency)</td>
<td>1</td>
</tr>
<tr>
<td>Dizziness/vertigo</td>
<td>1</td>
</tr>
<tr>
<td>Gender (male)</td>
<td>1</td>
</tr>
<tr>
<td>Any anti-epileptics</td>
<td>2</td>
</tr>
<tr>
<td>Any benzodiazepines</td>
<td>1</td>
</tr>
</tbody>
</table>
## Hendrich II Falls Risk Model

<table>
<thead>
<tr>
<th>RISK FACTOR ASSESSMENT</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GET UP</strong> Rises in a single movement</td>
<td>0</td>
</tr>
<tr>
<td><strong>AND</strong> Pushes up in one attempt</td>
<td>1</td>
</tr>
<tr>
<td><strong>GO</strong> Multiple attempts, successful</td>
<td>3</td>
</tr>
<tr>
<td><strong>TEST</strong> Unable to rise without assistance</td>
<td>4</td>
</tr>
</tbody>
</table>

- Score (Document under Observation Record)
# Morse Fall Scale

## Morse Fall Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Score</th>
<th>Patient Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falling (immediate or previous)</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 25</td>
<td></td>
</tr>
<tr>
<td>2. Secondary diagnosis (≥ 2 medical diagnoses in chart)</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 15</td>
<td></td>
</tr>
<tr>
<td>3. Ambulatory aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None/bedrest/nurse assist Crutches/cane/walker</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>4. Intravenous therapy/heparin lock</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 20</td>
<td></td>
</tr>
<tr>
<td>5. Gait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal/bedrest/wheelchair</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Weak*</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Impaired†</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>6. Mental status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oriented to own ability</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Overestimates/forgets limitations</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td><strong>Total Score‡</strong>: Tally the patient score and record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25: Low risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-45: Moderate risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;45: High risk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sitters or Patient Safety Attendant

- Patients who are at risk for self-harm or who are impaired and unable to follow instructions may need a sitter

- A sitter may also be ordered by the physician

- Provide continuous one to one observation

- Sitter responsible for maintaining safe environment

- Many hospitals that did away with sitter programs have reinstituted them
Sitters

- Hospital should have sitter policy
- 1:1 observation is required for patients in restraint and seclusion unless video/audio
- Sitters should never leave patient alone
- Work under the direction of the nurse and are often non-licensed
- Can be hospital employee with completed sitter competencies
- Note mixed results in the literature
SITTER GUIDELINES

GENERAL WORK GUIDELINES
1. The sitter reports to the charge nurse on arrival to the unit.

2. Personal Appearance Standards (2 PC 1001) are followed for sitter attire.

3. While the sitter’s preference is considered when assigning breaks and lunch times, overall patient needs take precedence over individual requests. The sitter may not leave for break without Registered Nurse (RN) permission and the provision of continuous monitoring during the sitter’s absence.

4. The sitter may not make or receive personal phone calls while on duty. This includes the use of personal cellular phones. In the case of an emergency, the sitter will notify the RN that he/she needs to take a break to make a telephone call and wait for someone to relieve him/her.

5. Sitters are not to sleep on duty.

6. Sitters are not permitted to eat or drink while on duty.

7. Sitter may have reading material while on duty, but it must not interfere with his/her duties to observe the patient.

PATIENT RIGHTS
1. The sitter may be present and overhear discussions related to the medical or psychiatric condition of the patient. These conversations are confidential and should not be repeated or shared with anyone.

2. The sitter does not engage in conversations with the patient regarding his/her medical or psychiatric condition or plan of care nor does he/she offer suggestions. The sitter will refer the patient to the nurse or physician to answer any questions regarding care.

3. The sitter monitors the patient’s verbalizations and immediately informs the nurse if the patient expresses any idea or intention to hurt self/others or leave without physician’s permission (elopement or Against Medical Advice (AMA)).

PATIENT CARE
1. Sitters observe the patient and maintain a safe environment and as delegated by the RN may...
PATIENT CARE

1. Sitters observe the patient and maintain a safe environment, and as delegated by the RN, may provide care to the patient that does not interfere with the ability to maintain continuous visual contact.
   
a. Non-licensed nursing staff assigned as sitters may complete all aspects of ADL’s for all patients in the room. This includes but is not limited to the following: vital signs, bathing, feeding, toileting, ROM and restraint protocol if appropriate.
   
b. Ancillary staff may provide care within the scope of their regular practice.

2. Sitters sit in the patient’s room with an unobstructed view of the patient. Patient requests for assistance are promptly referred to the nursing staff via the call light/intercom system.

3. The sitter accompanies the patient for any clinical tests or procedures off the unit. The sitter remains within an arm’s length distance of the patient unless otherwise directed by the person performing the test or procedure.

4. The sitter may be assigned to monitor two patients in the same room. The sitter positions him/herself to maintain an unobstructed view of both patients. Additional staff must be provided if patient activity (e.g., patient ambulating in the hall, patient in the restroom or patient transported off the unit) prevents the sitter from simultaneously monitoring both patients.
Patient Assessment Should be Done

- On admission
- When the patient’s condition changes (after surgery, new medication regimen, change in condition like onset of confusion, sustains a stroke, return form PT, etc.)
- When a fall or good catch (near miss) occurs
- When transferred to a new unit
- More often if high risk
Toileting

- Recent studies show that up to 50% of falls are related to toileting needs.
- 49% of falls involved left alone to void after being assisted to BR or BSC\(^1\)
- Regular toileting or bladder training may be especially helpful for patients/residents with cognitive impairment\(^2\)


See Meade, 2006; Quigley, 2008; Tzeng, 2009; Can reduce falls by 60%
## Toileting Worksheet

### Example Toileting Worksheet

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Wednesday</th>
<th>Before Brkfst 6am</th>
<th>After Brkfst 9am</th>
<th>After Lunch 1pm</th>
<th>After Dinner 6pm</th>
<th>Bed Time 8pm</th>
<th>11:30pm</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Outcome / Results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Staff Initials</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Thursday</strong></td>
<td>Before Brkfst 6am</td>
<td>After Brkfst 9am</td>
<td>After Lunch 1pm</td>
<td>After Dinner 6pm</td>
<td>Bed Time 8pm</td>
<td>11:30pm</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcome / Results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Staff Initials</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td>Before Brkfst 6am</td>
<td>After Brkfst 9am</td>
<td>After Lunch 1pm</td>
<td>After Dinner 6pm</td>
<td>Bed Time 8pm</td>
<td>11:30pm</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcome / Results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staff Initials**
NURSING: Fall Protocol and Algorithms

TITLE: Patient Fall Prevention & Management Protocol with Tolleting Program

PURPOSE: To identify patients at risk for falls; and, to outline recommendations for the nursing management of patients at risk for falls or who have a history of falls.

LEVEL: Independent

SCOPE OF PRACTICE: An RN initiates and discontinues this protocol. All nursing staff participate in interventions. The Morse Fall Scale is completed on all inpatients on admission.

INDICATIONS / SUPPORTIVE DATA: Patient falls are a high risk, high frequency problem in health care facilities. The consequences of falls include patient injury, discomfort, increased morbidity and mortality, increased treatment expenses, quality of care concerns, and (professional) liability. The potential for decreasing the number and severity of falls, decreasing costs, and increasing positive outcomes for patients is significant. This has been demonstrated by Evidenced Based Practice and by research results.

DEFINITION: A Fall is “A loss of upright position that results in landing on floor, ground or an object of furniture or sudden uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor, stairs, etc. (VHS Patient Personal Freedom and Security, Fall Prevention and Management, Oct 2001: published by DVA, VHA National Center for Patient Safety.)

I. NURSING ASSESSMENT:
A. The Morse Fall Scale (MFS) is used to assess all in-patients for fall risk.
B. All Patients will be assessed on admission.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY OF FALLING (Acute medical/surgical and geropsychiatric fall within 3 months)</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>GEC {NHCU &amp; Acute Psychiatry} fall within 6 months</td>
<td>Yes</td>
<td>25</td>
</tr>
</tbody>
</table>
Hourly Rounding

- Some hospitals do hourly rounding during the day and evening shift
- Found reduced number of call lights and falls
- Could answer call lights more promptly when patients needed to use to the bathroom
- Might be nurse visiting even hours and aide odd hours
- Use documentation form
- Evaluate if rounding reduced falls
Hourly Rounding Form

**Purpose:** The purpose of this log is for data collection on hourly patient rounding ensuring clinical accountability and keeping our patients and families informed.

**Instructions:** The log serves as documentation of hourly rounds. Completed logs are submitted to the Clinical Supervisor daily for review and compliance. The Manager will retain the log for 30 days.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Room #: (Do NOT include name)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Initials of Person Rounding</th>
<th>Time of Rounding Visit</th>
<th>Reason for Patient Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>6–7 a.m. 0600 - 0700</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7–8 a.m. 0700 - 0800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8–9 a.m. 0800 - 0900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9–10 a.m. 0900 - 1000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10–11 a.m. 1000 - 1100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 a.m.– 12 noon 1100 - 1200</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 noon – 1 p.m. 1200 - 1300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–2 p.m. 1300 - 1400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–3 p.m. 1400 - 1500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3–4 p.m. 1500 - 1600</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4–5 p.m. 1600 - 1700</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5–6 p.m. 1700 - 1800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6–7 p.m. 1800 - 1900</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sleeping Off unit / Out of room
Frequent Rounding Research


Bed Alarms

- Bed exit alarms warn caregivers when patients leave or attempt to leave their beds
- The Joint Commission cited bed alarms as an effective risk reduction technique
- Also has one of the root causes of problems when they malfunction or are misused
Bed Alarms

- Many forms such as pressure-sensitive pad which can be placed under buttocks
- Cords and garment clips, patient wears alarms that are attached directly to body such as ankle
- Floor mats with sensors and bedside infrared beam detectors that are set up next to the wall or bed
Education

What You Can Do to Prevent Falls

Many falls can be prevented. By making some changes, you can lower your chances of falling.

Fall Facts
- Falls are the leading cause of injury deaths and the most common cause for nonfatal injuries.
- More than one third of adults ages 65 and older fall each year in the United States.

Four things YOU can do to prevent falls:

1. Begin a regular exercise program
   Exercise is one of the most important ways to lower your chances of falling. It makes you stronger and helps you feel better. Exercises that improve balance and coordination (like Tai Chi) are the most helpful. Lack of exercise leads to weakness and increases your chances of falling. Ask your doctor or health care provider about the best type of exercise program for you.

2. Have your health care provider review your medicines
   Have your doctor or pharmacist review all the medicines you take, even over-the-counter medicines. As you get older, the way medicines work in your body can change. Some medicines, or combinations of medicines, can make you sleepy or dizzy and can cause you to fall.

3. Have your vision checked
   Have your eyes checked by an eye doctor at least once a year. You may be wearing the wrong glasses or have a condition like glaucoma or cataracts that limits your vision. Poor vision can increase your chances of falling.

4. Make your home safer
Give Patients Educational Material

Patient Handout
Falls: General Information

Falls occur frequently and are a major cause of disability and death in senior citizens. More than one third of people over the age of 65 have at least one fall each year.

Injuries sustained in a fall may range from trivial bruises to life-threatening trauma. Head injuries and fractures of long bones (for example, hip fractures) lead the list. It is important to realize there may be a delay in the onset of the effects of head injury.

Even falls that do not lead to injury can have a negative effect on older adults. After a fall, elderly patients often voluntarily restrict their activity because they fear another fall. This reduction in exercise leads to further weakness that, in turn, increases the risk of another fall—a vicious cycle.

Who is at Risk of Falling?

Everyone is at risk and risk for falls increases as we age. This increased risk of falling is likely the result of changes that come with aging, plus other medical conditions such as arthritis, cataracts or hip surgery.

How Can I Decrease My Risk of Falling?

Most falls occur in the home. You can make sure your home is safe by following these tips:

- Make sure that you have good lighting in your home. As you age, less light reaches the back of the eyes where your vision is located. Use night-lights in your bedroom, hall, and bathroom.
- Rugs should be firmly fastened to the floor or have nonskid backing. Loose ends should be tacked down.
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Blood Thinners: Risk Factors Associated with Falling and What to Do When You Fall

Dicates you are taking anticoagulant or anti-platelet medicine.
2. Carry a list of your current medication (prescribed and over-the-counter) on your person when you are out of the house. You could keep a copy of this list in your wallet or purse. Make sure this list is the same as the one you keep in your home for emergency personnel.
3. On your medication list, include the name and phone number of your healthcare provider, in case a stranger or emergency paramedic needs to call them.
4. If you require a mobility aid (such as a cane or walker) for safe transfers and/or walking, be sure to use your mobility aids as prescribed. These devices are prescribed to help you walk safely.
5. Treat all falls as serious. Call your healthcare provider and report your fall, even if you think that you were not hurt.
6. If you are on an anticoagulant, call your healthcare provider before taking any drug for pain to check on possible increased effect on bleeding.

For Family Members of a Person Taking Blood Thinners who has Fallen:
1. Check for injury and bleeding. DO NOT get the person up until you are certain there is no serious injury or bleeding.
   - Are they breathing? If not, call 911 and start CPR.
   - Are they bleeding? If yes, put pressure on the site of the bleeding, call 911 and inform them that the person takes an anticoagulant or anti-platelet medicine.

   - Did they lose consciousness? Are they more confused? If yes, call 911. If the person is confused, talk to the them and orient them to the situation.
   - Where do they hurt? Ask the person if they have pain anywhere. Look for any obvious fractures. Do NOT get the person up. Call 911 for help.

   2. Do NOT attempt to lift the person by yourself. Trying to lift a person can injure both of you.
   3. Reassure the person. They may be confused, frightened, and embarrassed. If possible, provide a calm environment, cover them with a blanket, and stay until help arrives.
   4. Ask for details about the fall, and get as much information as possible from any witnesses.
   5. Ask the person how long they have been taking blood thinners, what kind, and the last time they took their medication.
   6. As soon as possible notify the person’s healthcare provider about the fall. A fall can be a symptom of serious problems. Most falls can be prevented.

For more information contact:
VISN 8 Patient Safety Center
11605 N. Nebraska Ave.
Tampa, Fl. 33612-5738
813-558-3900

A NATIONAL VA FALLS COLLABORATIVE PROJECT
Patient Education

- **Call before You Fall!**
- Education is critical for both the patient and the family
- Give flyers in the admission packets and have in waiting room
- Give patient direct verbal information since may not read material
- Show the patient where the call cord is and location of the bathroom
Call...
Don't Fall
Patient and Family Education

- High risk male patients should be asked to urinate from a sitting position
- Explain to patient the risks of falling from medications
- Patients can be taught to walk close to wall and lean on wall if feels they are starting to fall
Documentation

- Documentation is important
- The fall assessment performed on all patients will be documented in the medical record
- Interventions that have been implemented should also be documented
- Incident reports are completed for each fall episode
### SECTION A: To be completed by clinical staff

<table>
<thead>
<tr>
<th>Location at time of fall (ward, clinic, service, etc.):</th>
<th>☐ Inpatient</th>
<th>☐ Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Fall: Time of fall (military):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Physician/ARNP/PA notified:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For inpatients, Date admitted/transfered to this ward:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of the event, including any obvious fall-related injuries (e.g., head trauma, change in ROM, pain, bruises, lacerations) and describe what was patient doing or trying to do that may have contributed to the fall:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Found on floor</td>
<td>☐ Staff lowered patient to floor</td>
<td>☐ Patient lowered self to floor</td>
</tr>
</tbody>
</table>

Was next of kin notified? ☐ Yes ☐ No (If no why not?)

### Contributory Factors (check all that apply):

#### Mobility:
- ☐ Up ad lib
- ☐ Wheelchair
- ☐ Ambulate with assistance
- ☐ Restraints

#### Environmental/Equipment (check all that apply):
- ☐ Floor wet
- ☐ Bed side rails (circle appropriate choice(s): all up or down, 1 up (left, right), top half up (left, right), bottom half up (left, right))
- ☐ Equipment faulty:
  - ☐ Shower chair/commode chair
  - ☐ Stretcher

#### Cognitive & Functional factors:
- ☐ Incontinent (circle appropriate choice(s): bowel or bladder)
- ☐ Confused/memory impaired
- ☐ Altered gait/balance
- ☐ Altered ADL

#### Assistive Devices:
- ☐ Assistive Devices involved in fall? ☐ No ☐ Yes
Documentation

Documentation in the medical record after a fall incident consists of the following:

- Patient assessment at time of discovery
- Patient response to fall
- Evidence of injury
- Description of fall (location and position of patient when found)
Documentation in the MR after a Fall

- Notification of patient’s physician
- Notification of patient’s family
- Any medical or nursing actions that were implemented
- If pictures were taken
- Patient assessment at time, date of discovery
- Patient response to fall (what patient said)
- Evidence of injury
- Medical or nursing action implemented
HCANJ Fall Management Guidelines

FALLS MANAGEMENT INVESTIGATION — POST FALL TOOL

Resident Name ___________________________ Age ______ Living Quarters Room # ________
Date of fall ______/____/____ Day of week ___________________ Time __________________ AM or PM

1. Was this fall observed? ☐ No ☐ Yes If yes, by whom: _____________________________ (name and title of individual)

2. Location of fall (be as exact as possible) _______________________________________

3. Was the resident alone at the time of the fall? ☐ Yes ☐ No

4. What was the reason for the resident to be in that location? ________________________

5. Was this the resident’s first fall? ☐ Yes ☐ No

6. Were protective or safety devices in use at the time of the fall? ☐ Yes ☐ No

7. Investigate the surroundings where the incident occurred for any evidence of the following:
   • The witness is to complete this section: ☐

<table>
<thead>
<tr>
<th>Clue</th>
<th>Yes</th>
<th>No</th>
<th>Clue</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water spills?</td>
<td></td>
<td></td>
<td>Resident in a hurry?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clutter on the floor?</td>
<td></td>
<td></td>
<td>Resident not using cane/walker as MD ordered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone cords/TV cords lying about?</td>
<td></td>
<td></td>
<td>Improper footwear?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor lighting?</td>
<td></td>
<td></td>
<td>Clothing got in the way?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper bed height?</td>
<td></td>
<td></td>
<td>Resident using incontinent supplies at time of fall?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other furniture involved?</td>
<td></td>
<td></td>
<td>Resident became tired?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair unlocked?</td>
<td></td>
<td></td>
<td>Resident reaching for items?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair foot-rests in the way?</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Has the resident's health care status changed? Answer the following questions: ☐

<table>
<thead>
<tr>
<th>Clue</th>
<th>Yes</th>
<th>No</th>
<th>Clue</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/increase/decrease in medications?</td>
<td></td>
<td></td>
<td>Decrease in fluid intake?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness/fatigue?</td>
<td></td>
<td></td>
<td>Recent fever/cough/cold?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness?</td>
<td></td>
<td></td>
<td>Changes in diagnosis status?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in blood pressure?</td>
<td></td>
<td></td>
<td>Changes in mental status?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent return from hospital?</td>
<td></td>
<td></td>
<td>Changes in behaviors?</td>
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</tbody>
</table>
Fall: Unplanned descent to the floor

- Minor harm: results in application of dressing or ice, elevation of limb, topical medication
- Moderate harm: results in suturing, steri-strips, fracture or splinting
- Major harm: surgery, casting, traction
- Death: (as a result of the fall)

(National Quality Forum)

Patient/Resident/Client Name: ________________________________
MRN: ____________________ Date of Fall: ________________ Time of Fall: ____________________
Location of Fall (specifically): ________________________________
What was the person trying to do? ________________________________
Was this the first fall? _______ Last fall date: ________________ Was the person being assisted? __________
Admission date: ________________ Risk Score on Admit: __________ Latest Risk Score: ________________
Was this person accurately scored at the time of the fall? ______ Other information: ____________________

**Hospital/Nursing Home: (Y/N or NA)**
- Bed/Chair/Tab Alarm activated? ______
- Was Call Light on? ________________
- Lights: Off/On? __________________
- Pt/Resident Restrained ____________
- Walker/Cane/W-chair _____________
- Wet Floor ______________________
- Furniture in the way ____________
- Other factor: ____________________

**Home Health Clients: (Y/N or NA)**
- LifeLine activated? ______________
- Was client supervised? __________
- Lights: Off/On? _________________
- Walker/Cane/W-chair ____________
- Wet Floor? _____________________
- Furniture in the way? ____________
- Other factors?: __________________

Current Diagnosis/Condition Information (check all that apply):
# POST FALL ASSESSMENT

**Admitting Diagnosis:**
- CVA
- TBI
- Ortho
- Other

**Fall occurred on** ____________ (date) **at** _______ **(time). Patient last checked at** _______ **(time).**

<table>
<thead>
<tr>
<th>History of previous falls? (Within the past 3 months)</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Any medical conditions that predispose to falls or underlying medical conditions that increase injury risk from falls?</td>
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<td>Was the patient identified as a fall risk?</td>
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<td>Were the precautions in place?</td>
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<td>If this was a transfer, was a gait belt in use?</td>
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<td>Was the patient wearing proper footwear?</td>
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<td>Were the brakes locked on the bed/wheelchair/stretcher?</td>
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<td>Personal items within reach?</td>
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<td>Call light used?</td>
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<tr>
<td>Environment free of clutter?</td>
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</table>

**Patient receiving any of these categories of medications?**
- Anticoagulants
- Anti-psychotics
- Antihypertensive
- Diuretics
- Narcotics
- Laxatives
- >5 Routine Medications
- Other (i.e. Antidepressants, Vasodilators)

**Recent change in medication?**

**Change in mobility, standing, sitting balance or activity tolerance?**

**Change in bowel and bladder continence status?**

**Any visual and auditory impairment?**

**Any changes in cognition, judgment, memory, safety awareness, decision-making capacity?**

**INTERVENTIONS (mark the new interventions)**

<table>
<thead>
<tr>
<th>Fall arm band applied to patient’s wrist</th>
<th>PT/OT consultation</th>
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</thead>
<tbody>
<tr>
<td>Reviewed medication therapy with Pharmacist</td>
<td>Modification of environmental factors</td>
</tr>
<tr>
<td>Increase patient observation/monitoring</td>
<td>As per device in place</td>
</tr>
</tbody>
</table>
• Skin - any lacerations, abrasions, skin tears, hematoma

• ROM - can the patient move arms and legs

• Environment - did the fall occur at the bedside, in bathroom, activity engaged in, wet floor, broken glass, etc.
Post Fall Assessment

- If high risk patient on **anticoagulants** experiences a fall in hospital, is referral for a PT screening needed to assess mobility? (since at high risk for injury, Coumadin, Heparin drip, Plavix, Lovenox, Integra, Low weight heparin)

- If patient on **psychotropic medication** falls in hospital, is referral to clinical pharmacist needed for medication review? (Antidepressants: Elavil, Norpramin, or Antipsychotic: Risperdal, Haldol, Geodon. Zyprexa, or Seroquel)
Post Fall Assessment

- Review fall prevention interventions and modify plan of care
- Should now institute high risk interventions if not already implemented
- Communicate to all shifts in report that patient has fallen and is high risk to fall again\(^1\)
- Physician checklist for assessing fall risk or performing post fall evaluation\(^2\)


\(^2\)http://www.cpgnews.org/FF/tools.cfm
<table>
<thead>
<tr>
<th>Table 3</th>
<th>Checklist for Assessing Fall Risk or Performing a Post-Fall Evaluation</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Assessing Fall Risk</td>
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<tr>
<td>Fall history</td>
<td>Review patient’s history of falls.</td>
</tr>
<tr>
<td>Medications</td>
<td>Review patient’s record for medications or combinations of medications that could predispose to falls. Stop or reduce the dosage of as many of these medications as possible.</td>
</tr>
<tr>
<td>Underlying conditions</td>
<td>Assess patient for underlying medical conditions that may predispose to falls, including conditions that affect balance or cause dizziness or vertigo.</td>
</tr>
<tr>
<td>Functional status</td>
<td>Assess level of mobility. Assess gait and standing / sitting balance. Assess lower extremity joint function. Assess ability to use ambulatory assistive devices (e.g., cane, walker). Review appropriateness and safety of any current restraints. Review activity tolerance. Assess for deconditioning. Review bowel and bladder continence status.</td>
</tr>
<tr>
<td>Neurological status</td>
<td>Assess patient for conditions that impair vision (e.g., cataracts, glaucoma, macular degeneration). Assess for sensory deficits, including peripheral neuropathies. Assess muscle strength, lower extremity peripheral nerves, proprioception, reflexes, motor and cerebellar function.</td>
</tr>
<tr>
<td>Psychological factors</td>
<td>Review for impaired cognition, judgment, memory, safety awareness, and decision-making capacity.</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Assess presence of environmental factors that could cause or contribute to falls. Assess whether patient’s footwear may be contributing to fall risk.</td>
</tr>
</tbody>
</table>
Post Fall Management

- Immediate assessment is performed by licensed healthcare provider
- If life threatening can call code team or rapid response team
- Seek appropriate assistance and equipment to get the patient off the floor
- Diabetics may want to check glucose
- Assess and document if patient denies striking head and there is no visible head trauma
Post Fall Management

- Observe for 24 hours with VS and neuro checks every four hours, observe for restrictions in mobility and notify physician.

- Determine in policy how often vital signs are to be done.
  - Q 30 minutes X4, Q 1 hours x4, Q 4 hours X24 post fall.

- Can differ depending on extent of injury or fall.
Post Fall Management

Minor Head Trauma-(No loss of consciousness or change in mental status. Example: headache, small laceration/contusion):

- Follow interventions listed above
- Perform neuro-checks every two hours for the first 12 hours, and every 4 hours for the following 24 hours
- Notify physician of fall and any assessment findings and charge nurse/manager
- Specifically make physician aware if patient is on anticoagulant therapy
# 3 Page Fall Evaluation Form

## Falls Evaluation: Initial Visit

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name</th>
<th>ROS (circle positives)</th>
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<tbody>
<tr>
<td>Age:</td>
<td></td>
<td>acute illness</td>
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<td>memory loss</td>
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<td>dizziness</td>
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<td>incontinence</td>
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<td>headache</td>
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<td>chest pain</td>
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<td></td>
<td>palpitations</td>
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<td>joint pain</td>
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<td>joint instability</td>
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<td>foot problems</td>
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<td>edema</td>
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<td>cane/walker</td>
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<td>help dress/bathe</td>
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<td>stairs</td>
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<td>walk block</td>
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<td>fear of falling</td>
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<td>insomnia</td>
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<td>Drugs Causing Falls</td>
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<td>Psychotropic medications</td>
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<td>Diuretics</td>
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<td>Antihypertensives</td>
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<td>Health Habits:</td>
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</table>

<table>
<thead>
<tr>
<th>Home Safety Ques.</th>
<th>Story of the Falls</th>
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<tbody>
<tr>
<td>(0=rare, no problem</td>
<td>Current Medical History/Treatments</td>
</tr>
<tr>
<td>3=Frequent/severe)</td>
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<td>Trips</td>
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<td>Handholds</td>
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<td>Light</td>
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<td>Footwear</td>
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<td>Toilet</td>
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<td>Bath</td>
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<td>Stairs</td>
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<td>Reach</td>
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<td>Outside</td>
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<td>Help</td>
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<thead>
<tr>
<th>Past Med Hx</th>
<th>Medical and Psychiatric History</th>
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<tbody>
<tr>
<td>(check positives)</td>
<td>Medications</td>
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<tr>
<td>Syncope</td>
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<td>Heart disease</td>
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<td>Seizures</td>
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<td>Renal Insufficiency</td>
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<td>Lung disease</td>
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<td>Alcoholism</td>
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<td>Vertigo</td>
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<td>Vision problems</td>
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<td>Arthritis</td>
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<td>Joint surgery</td>
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<td>Incontinence</td>
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</tbody>
</table>

[www.gericareonline.net/tools/eng/falls/](http://www.gericareonline.net/tools/eng/falls/)
<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>BP sit</th>
<th>BP standing</th>
<th>P__</th>
<th>T__</th>
<th>Wt. ___ lb</th>
<th>Ht. ___ in</th>
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<tr>
<td>Hearing</td>
<td>□</td>
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<tr>
<td>Intranasal</td>
<td>□</td>
<td></td>
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<tr>
<td>Ant. Oral</td>
<td>□</td>
<td></td>
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<tr>
<td>Oropharynx</td>
<td>□</td>
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<tr>
<td>Neck palp.</td>
<td>□</td>
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<tr>
<td>Thyroid</td>
<td>□</td>
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<tr>
<td>Resp. effort</td>
<td>□</td>
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<tr>
<td>Chest percss.</td>
<td>□</td>
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<tr>
<td>Chest palp.</td>
<td>□</td>
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<tr>
<td>Auscultation</td>
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<tr>
<td>Check nl, circ abn</td>
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<td>Upper extrem</td>
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<tr>
<td>Lower extrem</td>
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<tr>
<td>Mental status</td>
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<tr>
<td>DTRs</td>
<td>□</td>
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<tr>
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<td>□</td>
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<td>Orientation</td>
<td>□</td>
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<tr>
<td>Tandem walk</td>
<td>□</td>
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<td></td>
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<tr>
<td>One leg balance</td>
<td>□</td>
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<tr>
<td>Get up and Go Test</td>
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<tr>
<td>Sitting balance</td>
<td>□</td>
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<td>Arise w/arms folded</td>
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<tr>
<td>Standing balance</td>
<td>□</td>
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<tr>
<td>Eyes closed</td>
<td>□</td>
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<tr>
<td>Nudge</td>
<td>□</td>
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<td></td>
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<td>Gait initiation</td>
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<tr>
<td>Step length/ht</td>
<td>□</td>
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<tr>
<td>Step symmetry</td>
<td>□</td>
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<td>Pattern</td>
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<td>Path</td>
<td>□</td>
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<tr>
<td>Stance</td>
<td>□</td>
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</table>

| Psychiatric     |               |     |          |       |
| Mood            | □             |     |          |       |
| Memory          | □             |     |          |       |
| Thought process  | □             |     |          |       |
| Mood            | □             |     |          |       |
| Memory          | □             |     |          |       |
| Thought process  | □             |     |          |       |
Fall Incident Report

- Know your facility’s P&P on incident report process
- Include: date, time
- Location or place of fall
- Date of admission to the unit
- Description of the fall
- If pictures were taken
- Intrinsic and extrinsic factors
- If assessment was done as per policy
Fall Incident Report

- Previously implemented strategies
- Equipment in use at the time of the fall (cane, stretcher, bed, walker, WC, unavailable grab bars)
- Factors that contributed to fall (floor wet, lighting poor)
- New intervention and revision of plan of care
Preventing Falls in Older Patients

- One third of Americans over 65 fall each year
- 10-20% have moderate to severe injuries
- Guideline updated 2010 and 2011 from American Geriatric Society (AGS)
- Looked at new evidence available
- Ask if has fallen in past year, frequency, and if experiences difficulty walking or with balance (unsteady when they walk)
- If risk of falling then need assessment of home and interventions to eliminate fall risk factors
- Updates guidelines from American Academy of Orthopedic Surgeons published in 2001 and endorsed by many organizations (ACEP, AMA, AOTA (American Occupational Therapy Association), American PT Association)
Preventing Falls in Older Patients

- All healthcare practices for older adults should include:
  - Falls screening and preventions
  - Assessment of feet and foot wear
  - Fear of falling
  - Ability to carry out daily activities

- All interventions include an exercise component including starting tai chi and reducing medications

- Those with recurrent falls or gait problems undergo comprehensive fall risk assessment

*Journal of the American Geriatrics Society, Jan. 13, 2011*
Recommendations

- Daily Vitamin D supplement (800 IU)
- Boosting low blood pressure and manage heart rate abnormalities
- Cataract surgery should be performed when needed
- Medication reduction or withdrawal is recommended especially for sedatives, antidepressants, and drugs affecting the CNS
- Environmental adaptation by healthcare professional to reduce factors in the home etc.
Vitamin D May Help Prevent Falls 2014

Geriatrics Society Guidelines: Vitamin D May Prevent Falls
Laurie Barclay, MD
January 10, 2014

Older patients should receive sufficient vitamin D intake from all sources to lower their risk for falls and fractures, according to a new consensus statement published online December 18 in the Journal of the American Geriatrics Society. Dietary sources, sunlight, and supplements can all contribute to vitamin D levels of around 30 ng/mL (75 nmol/L), which appears to protect against fall-related injuries.

"In studies that achieved average serum levels greater than 25 ng/mL, falls and fracture rates were significantly reduced," James Judge, MD, chair of the American Geriatrics Society's (AGS's) Consensus Statement on Vitamin D Supplementation for Older Adults Work Group, told Medscape Medical News. "The impact on fractures is most likely due to the reduction in falls. In older adults, the impact of vitamin D on bone density is very small, while the impact on falls is measurable."

The consensus statement targets primary healthcare providers, aiming to help them ensure that community-dwelling and institutionalized older adults receive adequate vitamin D from all available sources. In addition to incorporating evidence from recent high-quality research, the statement is based on input from several medical organizations.
<table>
<thead>
<tr>
<th>Clinical recommendation</th>
<th>Evidence rating</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-dwelling older persons at risk of falls should receive multifactorial risk assessment and interventions tailored to their needs.</td>
<td>A</td>
<td>18,20</td>
</tr>
<tr>
<td>Nursing home residents at risk of falls should receive multifactorial risk assessment and interventions administered by a multidisciplinary team.</td>
<td>B</td>
<td>18,23</td>
</tr>
<tr>
<td>Older persons at risk of falls who have been hospitalized for an extended time in a subacute setting should receive multifactorial risk assessment and interventions tailored to their needs.</td>
<td>B</td>
<td>23</td>
</tr>
<tr>
<td>The following components should be included in multifactorial interventions for falls:</td>
<td></td>
<td>18,20</td>
</tr>
<tr>
<td>• Exercise, particularly balance, strength, and gait training</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>• Adaptation or modification of home environment for older adults who have fallen or who have visual impairment</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>• Withdrawal or minimization of psychoactive medications</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>• Withdrawal or minimization of other medications</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>• Management of postural hypotension</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>• Management of foot problems and footwear</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>The health care professional or team conducting the fall risk assessment should directly implement the interventions or should ensure that other qualified health care professionals carry out the interventions.</td>
<td>C</td>
<td>1,18</td>
</tr>
<tr>
<td>All older persons with proven vitamin D deficiency living in the community</td>
<td>A</td>
<td>18,20,23.37</td>
</tr>
</tbody>
</table>
Preventing Falls

- The most effective trials for preventing falls in older people looked at multiple interventions rather than just one; previous studies have indicated that it is more effective to focus on one intervention, but because we looked at not only what recommendations were given, but also which carried out, we're confident that multifactorial interventions is the best course of action”

- Dr Mary Tinetti Yale U. School of Medicine
AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons

Summary of Recommendations

SCREENING AND ASSESSMENT

1. All older individuals should be asked whether they have fallen (in the past year).
2. An older person who reports a fall should be asked about the frequency and circumstances of the fall(s).
3. Older individuals should be asked if they experience difficulties with walking or balance.
4. Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or report difficulties in walking or balance (with or without activity curtailment) should have a multifactorial fall risk assessment.
5. Older persons presenting with a single fall should be evaluated for gait and balance.
6. Older persons who have fallen should have an assessment of gait and balance using one of the available evaluations.
7. Older persons who cannot perform or perform poorly on a standardized gait and balance test should be given a multifactorial fall risk assessment.
8. Older persons who have difficulty or demonstrate unsteadiness during the evaluation of gait and balance require a multifactorial fall risk assessment.
9. Older persons reporting only a single fall and reporting or demonstrating no difficulty or unsteadiness during the evaluation of gait and balance do not require a fall risk assessment.
10. The multifactorial fall risk assessment should be performed by a clinician (or clinicians) with appropriate skills and training.
11. The multifactorial fall risk assessment should include the following:

   Focused History
   a. History of falls: Detailed description of the circumstances of the fall(s),
INTERVENTIONS

OLDER PERSONS LIVING IN THE COMMUNITY

12. The multifactorial fall risk assessment should be followed by direct interventions tailored to the identified risk factors, coupled with an appropriate exercise program. [A]
13. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified. [A]
14. The components most commonly included in efficacious interventions were:
   a. Adaptation or modification of home environment [A]
   b. Withdrawal or minimization of psychoactive medications [B]
   c. Withdrawal or minimization of other medications [C]
   d. Management of postural hypotension [C]
   e. Management of foot problems and footwear [C]
   f. Exercise, particularly balance, strength, and gait training [A]
15. All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]
16. Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]
17. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]
18. Psychoactive medications (including sedative hypnotics, anxiolytics, antidepressants) and antipsychotics (including new antidepressants or antipsychotics) should be minimized or withdrawn, with appropriate tapering if indicated. [B]
19. A reduction in the total number of medications or dose of individual medications should be pursued. All medications should be reviewed, and minimized or withdrawn. [B]
20. Exercise should be included as a component of multifactorial interventions for fall prevention in community-residing older persons. [A]
21. An exercise program that targets strength, gait and balance, such as Tai Chi or physical therapy, is recommended as an effective intervention to reduce falls. [A]
22. Exercise may be performed in groups or as individual (home) exercises, as both are
STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Health Care Providers

Did you realize that one out of three people 65 and older falls each year?

The good news is that health care providers can help reduce their patients’ chances of falling and of suffering serious injuries like hip fractures and traumatic brain damage.

CDC’s Injury Center created the STEADI Tool Kit for health care providers who see older adults in their practice who are at risk of falling or who may have fallen in the past. The STEADI Tool Kit gives health care providers the information and tools they need to assess and address their older patients’ fall risk.

Order Tool Kits

Printed materials will be available for order in Winter 2012-2013. If you are interested in pre-ordering a copy, please email us your name and address.

Download the STEADI Tool Kit materials

Read more... »
Download STEADI Tool Kit Materials

Make Fall Prevention Part of Your Practice

- Triage Your Patients Based on Fall Risk
  This tool walks health care providers through assessing a patient’s fall risk, educating patients, selecting interventions, and following up.

- Have Your Patients Check Their Risk of Falling
  This brochure offers a checklist that patients can use to check their risk of falling.

- Prevent Falls in Older Patients, Provider Pocket Guide
  This small, easy-to-use tool walks health care providers through key points of fall prevention.

- See Your Patient’s Risk at a Glance
  This checklist allows health care providers to summarize an older patient’s fall risk.

- Integrate Fall Prevention into Your Practice
  This wall chart helps health care providers determine who in their practice will be responsible for conducting fall risk assessments, delivering interventions, and providing education to older patients.

- Talk about Fall Prevention with Your Patients
  This document can help health care providers comfortably talk about fall prevention with patients.

www.cdc.gov/homeandrecreationalSafety/Falls/steadi/index.html#download
## Fall Risk Checklist

<table>
<thead>
<tr>
<th>Fall Risk Factor Identified</th>
<th>Factor Present?</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td><strong>Falls History</strong></td>
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<tr>
<td>Any falls in past year?</td>
<td>Yes ☐</td>
<td>No ☑</td>
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<tr>
<td>Worries about falling or feels unsteady when standing or walking?</td>
<td>Yes ☐</td>
<td>No ☑</td>
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<tr>
<td><strong>Medical Conditions</strong></td>
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<td></td>
</tr>
<tr>
<td>Problems with heart rate and/or rhythm</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>Depression</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>Foot problems</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>Other medical conditions (Specify)</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any psychoactive medications, medications with anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, TYLENOL PM)</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td><strong>Gait, Strength &amp; Balance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timed Up and Go (TUG) Test</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>&gt;12 seconds</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td>30-Second Chair Stand Test</td>
<td>Yes ☐</td>
<td>No ☑</td>
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<tr>
<td>Below average score (See table on back)</td>
<td>Yes ☐</td>
<td>No ☑</td>
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<tr>
<td><strong>4-Stage Balance Test</strong></td>
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<tr>
<td>Full tandem stance &lt;10 seconds</td>
<td>Yes ☐</td>
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<tr>
<td><strong>Vision</strong></td>
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<tr>
<td>Acuity &lt; 20/40 OR no eye exam in &gt;1 year</td>
<td>Yes ☐</td>
<td>No ☑</td>
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<tr>
<td><strong>Postural Hypotension</strong></td>
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<tr>
<td>A decrease in systolic BP ≥ 20 mm Hg or a diastolic bp of ≥ 10 mm Hg or lightheadedness or dizziness from lying to standing?</td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td><strong>Other Risk Factors (Specify)</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Yes ☐</td>
<td>No ☑</td>
</tr>
<tr>
<td></td>
<td>Yes ☐</td>
<td>No ☑</td>
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</tbody>
</table>
Medications Linked to Falls

Although many medication classes have been linked to falls, the evidence is strongest for a few drug categories. Medication management can reduce interactions and side effects that may lead to falls.

Medication management means:
- Eliminating medications if there is no active indication
- Reducing doses of necessary medications (e.g., antihypertensives) to the lowest effective dose
- Avoiding prescribing medications for an older person where the risk from side effects outweighs the benefit (e.g., skeletal muscle relaxants)

The MOST important intervention is to reduce or eliminate:
- Psychoactive drugs, especially any benzodiazepines
- Any medications that have anticholinergic side effects
- Sedating OTCs, specifically Tylenol PM (which contains Benadryl) and Benadryl

For more information about geriatric medication management, go to the American Society of Consultant Pharmacists website at: www.ascp.com
Use Technology To Reduce Falls

- November 2010 JAMA article found that using health information technology reduced falls in patients over 65 by 25%

- Nurse entered risk assessment into the computer

- Computer printed out interventions to follow for the patient

- Printed out education material for the patient and family

- Printed out a fall plan of care and signs
Fall Prevention in Acute Care Hospitals

A Randomized Trial

Patricia C. Dykas, RN, DNSc; Diane L. Carroll, RN, PhD, BC; Ann Hurley, RN, DNSc; Stuart Lipsitz, ScD; Angela Benoit, BComm; Frank Chang, MSE; Seth Meltzer; Ruslana Tsurikova, MSc, MA; Lyubov Zuyov, MA; Blackford Middleton, MD, MPH, MSc


Context Falls cause injury and death for persons of all ages, but risk of falls increases markedly with age. Hospitalization further increases risk, yet no evidence exists to support short-stay hospital-based fall prevention strategies to reduce patient falls.

Objective To investigate whether a fall prevention tool kit (FPTK) using health information technology (HIT) decreases patient falls in hospitals.

Design, Setting, and Patients Cluster randomized study conducted January 1, 2009, through June 30, 2009, comparing patient fall rates in 4 urban US hospitals in units that received usual care (4 units and 5104 patients) or the intervention (4 units and 5160 patients)
Have a Safety Huddle Before & After the Fall

---

### Safety Huddle Form

**DATE:**

<table>
<thead>
<tr>
<th>Shift: 3rd</th>
<th>Shift: 1st</th>
<th>Shift: 2nd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 3 Patients for Fall Precautions</td>
<td>Top 3 Patients for Fall Precautions</td>
<td>Top 3 Patients for Falls Precautions</td>
</tr>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td>3.</td>
<td>3.</td>
</tr>
</tbody>
</table>

**Patient/Family Issues**

| 1. | 1. | 1. |

**Most Unstable Patient**

| 1. | 1. | 1. |

**Highest Acuity**

| 1. | 1. | 1. |
The End!       Questions?

Sue Dill Calloway RN, Esq
AD, BA, BSN, MSN, JD CPHRM
President
Patient Safety and Health Care Consulting
5447 Fawnbrook Lane
Dublin, Ohio 43017
614 791-1468
sdill1@columbus.rr.com

More resources follow
Can you pass the test?
AHRQ Toolkit Has a Test

Fall Knowledge Test
Each question may have more than one option as the correct answer.

Please circle the letters that correspond to the correct answers.

1. Which of the following statements is correct?
   a. Falls have multifactorial etiology, so fall prevention programs should comprise multifaceted interventions.
   b. Regular review of medication can help to prevent patient falls.
   c. The risk of falling will be lessened when a patient’s toileting needs are met.
   d. The use of antipsychotic medications is associated with an increased risk of falls in older adults.

2. A multifaceted intervention program should include:
   a. Individually-tailored fall prevention strategies
   b. Education to patient/family and health care workers
   c. Environmental safety
   d. Safe patient handling

3. Risk factors for falls in the acute hospital include all of the following except:
   a. Dizziness/vertigo
   b. Previous fall history
   c. Antibiotic usage
   d. Impaired mobility from stroke disease

4. Which of the following statements is true?

4. Which of the following statements is true?

a. The cause of a fall is often an interaction between patient’s risk, the environment, and patient risk behavior.
b. Increase in hazardous environments increases the risk of falls.
c. The use of a patient identifier (e.g., identification bracelet) helps to highlight to staff those patients at risk for falls.
d. A fall risk assessment should include review of history of falls, mobility problems, medications, mental status, continence, and other patient risks.

5. Patients with impaired mobility should be:

a. Confined to bed
b. Encouraged to mobilize with assistance
b. Assisted with transfers
d. Referred for exercise program or prescription of walking aids as appropriate
6. The management of the acutely confused patient should include all of the following except:
   a. Moving patients away from the nursing station
   b. Involving family members to sit with the patient
   c. Orienting patients to the hospital environment
   d. Reinforcing activity limits to patients and their families

7. Which of the following statements is false?
   a. Fall prevention efforts are solely the nurses’ responsibility.
   b. A patient who is taking four or more oral medications is at risk for falling.
   c. A patient who is taking psychotropic medication is at higher risk for falling.
   d. Testing or treatment for osteoporosis should be considered in patients who are at high risk for falls and fractures.

8. In hospital settings, intervention programs should include:
   a. Staff education on fall precautions
   b. Provision and maintenance of mobility aids
   c. Postfall analysis and problem-solving strategy
   d. Bed alarms for all patients, regardless of risk

9. When assessing patients, which of the following statements is false?
   a. All patients should be assessed for fall risk factors at admission, at a change in status, after a fall, and at regular intervals.
   b. Medication review should be included in the assessment.
   c. All patients should have their activities of daily living and mobility assessed.
   d. Environmental assessment is not important in the hospital as it is all standardized.
Health Care Protocol
Prevention of Falls (Acute Care)

How to cite this document:

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- the ICSI Health Care Protocol may be adapted or adapted for use within the medical group only.
Protocol

Perform risk assessment to identify risk factors (Annotation #3)
- Test for cognitive dysfunction (dementia, delirium)
- Assess gait and mobility function
- Identify potential medication factors
- Perform an environmental safety assessment

Communicate risk factors (Annotation #4)
- Use visual communication tools
- Inform patient and family of risks
  - Describe organization's falls prevention program – discuss how patient/family can assist with falls prevention and when/how to contact staff when necessary
  - Patient education
- Communicate patient falls risk to all members of the health care team

Perform risk factor interventions (Annotation #3)
- Establish universal falls interventions for all patients
- Implement behavioral interventions
- Implement impaired mobility interventions
- Perform environmental rounds
3 Excellent Falls Resources

- VHA National Center for Patient Safety Falls Toolkit
  http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html

- Institute for Clinical Systems Improvement Prevention of Falls (Acute Care) Protocol
  https://www.icsi.org/_asset/dcn15z/Falls-Interactive0412.pdf

- IHI Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls
  http://www.ihi.org/knowledge/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx
Resources

- Pennsylvania Patient Safety Advisory
  [Link](http://patientsafetyauthority.org/pages/bbtresults.aspx?Filter1Field=Event&Filter1Value=Fall)
http://ltctoolkit.rnao.ca/resources/falls

Resources: Falls prevention and management

The following resource is designed to assist Long-Term Care (LTC) homes with the implementation of the Prevention of Falls and Fall Injuries in the Older Adult Best Practice Guideline. Documents found in this resource are evidence-based, but it is not a program plan. Each LTC home is unique and each home is in various stages of guideline implementation. LTC homes are advised to use the resource at their discretion. For those resources that have copyright notations, it is recommended that LTC homes obtain permission from the primary author prior to implementing them within their setting. The Toolkit is a dynamic resource, and is being updated and revised on a regular basis by the LTC Best Practices Initiative team. Visit this site often to see what's new.

Disclaimer
Submit a Resource
Feedback

To view PDF format files, you need to have Adobe Acrobat Reader installed on your computer. You can download this free software from the Adobe Web site.

- Best Practices/Standards
- Assessment Tools
- Planning & Implementation Tools
- Quality Improvement Tools
- Additional Implementation Resources
- Policies and Procedures
- Care Planning
## Best Practices/Standards

<table>
<thead>
<tr>
<th>Resource</th>
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<tbody>
<tr>
<td>RNA0 Best Practice Guideline (BPG) Prevention of Falls and Fall Injuries in the Older Adult</td>
<td><img src="1" alt="PDF" /></td>
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<tr>
<td>RNA0 Prévention des chutes et des blessures associées chez la personne âgée RNA0 Best Practice Guideline (BPG) Prevention of Falls and Fall Injuries in the Older Adult in French.</td>
<td><img src="1" alt="PDF" /></td>
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<tr>
<td>RNA0 BPG – Summary of Recommendations for Prevention of Falls and Fall Injuries in the Older Adult</td>
<td><img src="1" alt="PDF" /></td>
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<tr>
<td>RNA0 Prevention of Falls and Fall Injuries in the Older Adult PDA Guideline Condensed version of the Falls BPG viewable on Personal Digital Assistants (PDAs) or mobile phones.</td>
<td><img src="1" alt="Adobe" /></td>
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<tr>
<td>College of Nurses of Ontario Practice Standards Restraint Policy Includes restraint descriptions, least restraint policy, and nursing responsibilities.</td>
<td><img src="1" alt="PDF" /></td>
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<tr>
<td>Gap Analysis Worksheet for Falls Worksheet identifies gaps in current practices related to Falls prevention.</td>
<td><img src="1" alt="PDF" /></td>
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<tr>
<td>Patient Restraints Minimization Act 2001 The government of Ontario’s Act on restraints.</td>
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## Assessment Tools

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<tr>
<td>Berg Balance Scale This scale rates a resident’s balance, and in turn, can be used to help determine resident fall risk. Available at <a href="http://www.fallpreventiontaskforce.org/pdf/BergBalanceScale.pdf">http://www.fallpreventiontaskforce.org/pdf/BergBalanceScale.pdf</a>.</td>
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<tr>
<td>MOHLTC Critical Incident</td>
<td><img src="Adobe" alt="PDF" /></td>
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<tr>
<td>This form is mandatory for falls resulting in significant injury. It would be best to incorporate this form into policy and procedure.</td>
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<tr>
<td>Morse Falls Scale</td>
<td><img src="Adobe" alt="PDF" /></td>
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<tr>
<td>This scale requires systematic, reliable assessment of a client’s fall risk factors upon admission, after a fall, with a change in status, and at discharge or transfer to a new setting. <strong>Available</strong>: The National Center for Patient Safety (NCPS). <strong>Author</strong>: Morse, J. M., Morse, R., &amp; Tylko, S. (1989)</td>
<td></td>
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<tr>
<td>Post Fall Investigation</td>
<td><img src="Adobe" alt="Image" /></td>
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<tr>
<td>The incident reporting forms help determine who fell and why, and looking at these factors help discover how to prevent falls.</td>
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<tr>
<td>Tinetti Balance and Gait Evaluation Tool</td>
<td><img src="Adobe" alt="PDF" /></td>
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<tr>
<td>These tools can be found and a tutorial is available at <a href="http://geriatrics.uthscsa.edu/tools/TINETTI.pdf">http://geriatrics.uthscsa.edu/tools/TINETTI.pdf</a>.</td>
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### Planning & Implementation Tools

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<td>RNAO Toolkit: Implementation of clinical practice guidelines</td>
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<tr>
<td>RNAO Trouss sur la marche à suivre</td>
<td><img src="Adobe" alt="PDF" /></td>
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<tr>
<td>Mise en place des lignes directrices pour la pratique Clinique.</td>
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Administration of the Tinetti Gait & Balance Instrument

The Tinetti Gait and Balance Instrument is designed to determine an elders risk for falls within the next year. It takes about 8-10 minutes to complete. The evaluator should review the questions prior to evaluation of the patient and ask any questions regarding the Instrument prior to beginning. The patient is asked to complete the gait portion first with the evaluator walking close behind the elder and evaluating gait steppage and drift. The patient is then asked to complete the balance portion with the evaluator again standing close by the patient (towards the right and in front). The patient is then asked to sit and the score is then totaled.

**Scoring**— The higher the score, the better the performance. Scoring is done on a three point scale with a range on each item of 0-2 with 0 representing the most impairment. Individual scores are then combined to form three scales: a Gait Scale, a Balance Scale and then and overall Gait and Balance score. The maximum score for gait is 12 points while the maximum for Balance is 16 points with a total maximum for the overall Tinetti Instrument of 28 points.

Score Interpretation

- <19  High Risk for Falls
- 19-24  Risk for Falls

**Not Clear on What Steppage Is?**—Evaluators usually have the most questions about steppage. For a complete tutorial on gait analysis click below.

[Gait Analysis Tutorial]
Patient Falls (1–20 of 65):

1. **Study:** Applying root cause analysis to improve patient safety: decreasing falls in postpartum women.

2. **Review:** Adverse events experienced by homecare patients: a scoping review of the literature.

3. **Commentary:** The patient who falls: "It's always a trade-off."
   Tinetti ME, Kumar C. JAMA. 2010;303:258-266.

4. **Book/Report:** Adverse Health Events in Minnesota: Sixth Annual Public Report.
Chapter 10. Fall and Injury Prevention

Leanne Currie

Background

Fall and injury prevention continues to be a considerable challenge across the care continuum. In the United States, unintentional falls are the most common cause of nonfatal injuries for people older than 65 years. Up to 32 percent of community-dwelling individuals over the age of 65 fall each year, and females fall more frequently than males in this age group.\textsuperscript{1, 2} Fall-related injuries are the most common cause of accidental death in those over the age of 65, resulting in approximately 41 fall-related deaths per 100,000 people per year. In general, injury and mortality rates rise dramatically for both males and females across the races after the age of 85, but males older than 85 are more likely to die from a fall than females.\textsuperscript{2-6} Unfortunately, fall-related death rates in the United States increased between 1999 and 2004, from 29 to 41 per 100,000 population.\textsuperscript{2, 7} Sadly, these rates are moving away from the Healthy People 2010 fall-prevention goal, which specifically seeks to reduce the number of deaths resulting from falls among those age 65 or older from the 2003 baseline of 38 per 100,000 population to no more than 34 per 100,000.\textsuperscript{8} Thus, falls are a growing public health problem that needs to be addressed.

The sequelae from falls are costly. Fall-related injuries account for up to 15 percent of rehospitalizations in the first month after discharge from hospital.\textsuperscript{9} Based on data from 2000, total annual estimated costs were between $16 billion and $19 billion for nonfatal, fall-related injuries and approximately $170 million dollars for fall-related deaths across care settings in the community.\textsuperscript{10, 11} Several factors have been implicated as causes of falls and injuries; to date, however, no definitive predictor profile has been identified. Although the underlying status of
# Falls Tool Kit

The Falls Tool Kit is used for the initial evaluation and management of a patient who experiences falls, and provides educational materials to teach patients how to reduce their risk of falling.

Click on the title of an individual tool for a short description and download options. Or download the complete toolkit by clicking on the links in the right-hand column.

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<td>Prepare</td>
<td>Home Safety Questionnaire</td>
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Hill-Rom No Fails Program

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Get Up and Go Test

Get Up and Go Test

The “Get Up and Go Test” is an assessment that should be conducted as part of a routine evaluation when dealing with older persons. Its purpose is to detect “fallers” and to identify those who need evaluation.

The staff should be trained to perform the “Get Up and Go Test” at check-in and query those with gait or balance problems for falls.

INITIAL CHECK
All older persons who report a single fall should be observed as they:
• From a sitting position, stand without using their arms for support.
• Walk several paces, turn, and return to the chair.
• Sit back in the chair without using their arms for support.

Individuals who have difficulty or demonstrate unsteadiness performing this test require further assessment.

FOLLOW-UP ASSESSMENT
In the follow-up assessment, ask the person to:
• Sit.
• Stand without using their arms for support.
• Close their eyes for a few seconds, while standing in place.
• Stand with eyes closed, while you push gently on his or her sternum.
• Walk a short distance and come to a complete stop.
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Thank you for attending!

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