

# Home Health Quality Improvement National Campaign

The Home Health Quality Improvement (HHQI) National Campaign is an initiative by the **Centers for Medicare & Medicaid Services (CMS)**, an agency of the U.S. Department of Health and Human Services, in conjunction with the Home Health Quality Improvement Organization Support Center (HHQIOSC) – **Quality Insights of Pennsylvania**. The campaign is based upon educating the leadership and care providers on best practice interventions to reduce avoidable acute care hospitalizations.

The monthly Best Practice Intervention Packages are a compilation of background information, leadership guidance, implementation tools and discipline specific education and application materials specific to the targeted best practice of the month. The best practice intervention packages have been designed for all agency clinical disciplines, support staff, administration, and management to use effortlessly to strive towards reducing avoidable acute care hospitalizations (ACH). The intervention packages are located on the Home Health Quality Improvement National Campaign Web site – [www.homehealthquality.org](http://www.homehealthquality.org) and will be available through February 29, 2008.

## Best Practice Intervention Package – Fall Prevention Therapy Track

### A. Target Audience:

1. Describe the target audience expected to participate: Home health agency therapist (Physical Therapists, Physical Therapy Assistants, Occupational Therapists, Certified Occupational Therapists Assistants and Speech/Language Pathologists)

### B. Purpose:

1. To provide education to home health therapist related to the specific best practice intervention: **Fall Prevention** - to assist with reducing avoidable acute care hospitalizations.

### C. Presenters/Content Specialists: The primary contributors for the Best Practice Intervention Package – Fall Prevention include the following individuals; their biographical data forms are attached.

1. Presenter Name, Degrees and Credentials:

- a. Misty Kevech, RN, BS Ed, MS
- b. Eve Esslinger, BSN, MS
- c. Bonnie Kerns, RN, BSN

2. A Technical Expert Panel was also utilized for a detailed review of the package. This interdisciplinary panel is located on page 8.

3. The HHQI Medical Advisory Panel contributed their expertise in the packages. The list of the members of this panel is located on page 9.

### D. Educational Package Outline Table:

1. Objectives, Content and Teaching Methods, Strategies, Materials and Resources. This table (1) indicates what the participant will be able to do at the conclusion of the activity and (2) provides an outline of the content, teaching methods and resources for facilitated the independent learning activity. See page 3.

**E. Therapy Requirements and Time Frame:**

1. Therapist activity table located on page 11

**J. Evaluation:**

1. Check or describe the methods of evaluation to be used (Check all that apply):

- Evaluation Form (Required for all events)
- Post test (Optional) If post-test is used, what is passing score? 80%
- Return Demonstration (Optional)
- Other - Describe: \_\_\_\_\_

**K. Verification of Participation and Completion:**

1. Attendance/participation will be verified at the event through sign in sheets/attendance sheets.

- Internet registration
- Other - Describe: \_\_\_\_\_

2. Criteria for completion include: (Check all that apply)

- Attendance at entire event
- Attendance at individual sessions
- Completion/submission of evaluation form
- Achieving passing score on posttest
- Completion of self-study packet
- Skills demonstration
- Other - Describe: \_\_\_\_\_

3. Participant will be informed of criteria by (check all that apply):

- Information on brochure/advertising material (Criteria for successful completion must be included on advertising)
- Verbal statement at beginning of activity
- Written information on handouts/website
- Other - Describe: \_\_\_\_\_

4. **Certificate of Participation** will be send electronically to the therapist within 30 days of successfully completing the evaluation/post-test.

Any questions related to the continuing education components please contact Misty Kevech – [mkevech@wvmi.org](mailto:mkevech@wvmi.org)



**Best Practice Intervention Package (BPIP) – Fall Prevention  
Educational Package Outline  
Independent Study**

OBJECTIVES	CONTENT (Topics)	METHODS
List all learner’s objectives in behavioral terms <b>At the end of this activity, the learner will be able to:</b>	Provide an outline of the content for each objective.	Describe the teaching methods, strategies, materials & resources for each objective
1. Recognize the need for more than just a fall risk assessment for an effective home health fall prevention program.	<ol style="list-style-type: none"> <li>1. Definitions of Fall and Fall Prevention</li> <li>2. Statistics to demonstrate the significance of falls and the need for fall prevention programs</li> <li>3. Listen to successes of implementing fall prevention program to reducing falls.</li> </ol>	<input checked="" type="checkbox"/> BPIP – Fall Prevention - <b>Therapy Track</b> <input checked="" type="checkbox"/> Therapist’s Guide to Fall Prevention <input checked="" type="checkbox"/> Podcast (audio recording), “Fall Prevention for Clinicians” <b>Adult learning principles:</b> Respect of learner’s learning preference Sequencing and Reinforcement Relevance Accountability
2. Describe how fall prevention program will support reducing avoidable acute care hospitalizations.	<ol style="list-style-type: none"> <li>1. Definition of Fall Prevention               <ol style="list-style-type: none"> <li>1.1 Briggs National Quality Improvement/Hospitalization Reduction Study, 2006</li> </ol> </li> <li>2. Therapist’s Guide to Practical Application               <ol style="list-style-type: none"> <li>2.1 Statistics to demonstrate the incidence of falls and ACH and injury</li> </ol> </li> <li>3. Podcast               <ol style="list-style-type: none"> <li>3.1 Agency description on how to successfully implement Fall Prevention program and reduce ACH</li> </ol> </li> <li>4. Examples of Excellence               <ol style="list-style-type: none"> <li>4.1 Demonstration of fall prevention program success in reducing ACH</li> </ol> </li> </ol>	<input checked="" type="checkbox"/> BPIP – Fall Prevention – <b>Therapy Track</b> <input checked="" type="checkbox"/> Fall Prevention Therapist’s Guide to Practical Application <input checked="" type="checkbox"/> Podcast (audio recording) – “Fall Prevention for Clinicians” <input checked="" type="checkbox"/> Examples of Excellence – success stories <b>Adult learning principles</b> Respect of learner’s learning preference Sequencing and Reinforcement Lecture Relevance Accountability
3. Describe two therapy actions that will ensure optimal fall prevention for staff, patients and caregivers.	<ol style="list-style-type: none"> <li>1. Therapist’s Guide to Practical Application               <ol style="list-style-type: none"> <li>1.1 Clinical application points for therapist related to promoting a successful fall prevention program</li> <li>1.2 Fall Risk Assessment tool, risk factors and potential interventions for Fall Prevention</li> </ol> </li> <li>2. Tools to improve clinician assessment techniques</li> <li>3. Examples of Excellence               <ol style="list-style-type: none"> <li>3.1 Two success stories showing implementation of fall prevention program to assist with reducing avoidable ACH.</li> </ol> </li> </ol>	<input checked="" type="checkbox"/> BPIP – Fall Prevention – <b>Therapy Track</b> <input checked="" type="checkbox"/> Fall Risk Assessment tool <input checked="" type="checkbox"/> Accurately Assessing Orthostatic Hypotension <input checked="" type="checkbox"/> Timed Up and Go instruction sheet/PowerPoint <input checked="" type="checkbox"/> Examples of Excellence <b>Adult learning principles:</b> Respect of learner’s learning preference Sequencing and Reinforcement Accountability Relevance

# Misty Kevech's Biographical Data Form

**This individual is:** (Check all that apply)

- Administratively Responsible Person
- Planning Committee Member
- Presenter/Content Specialist

## BIOGRAPHICAL DATA FORMS

Instructions: Make as many copies of this form as necessary to provide the required information documenting adherence to the criteria. *Do not* send curriculum vitae. Form must be typed or word-processed.

**Name, degree and credentials:**

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**Present position (title)**

Communications/Training Manager

**Employer:**

Quality Insights of Pennsylvania

### Planners:

Describe your professional qualifications and familiarity with the target audience

The target audience for this learning session is home health quality improvement managers or administrators. Misty Kevech has been a Registered Nurse for over 27 years, including 22 years in home care. Ten years of her experience has been in Quality Improvement. Misty also is credentialed with Certified OASIS – Clinical (COS-C), which assists in educating on outcome measures. Misty has additional degrees of BS Ed in Public Nursing (California University of Pennsylvania) and MS in Leadership with an emphasis on Training and Development (Carlo College) to assist with adult education. ACH, Ready, Aim, Improve Learning Session #3 – Works with home health agencies in Pennsylvania with development, implementation and evaluation of plans of actions to improve quality outcome measures. Misty also educates the agencies on strategies and best practices. SBAR – Participated in the three part series by IHI on SBAR. Telehealth – Planned and developed previous telehealth WebEx educational activities: Home Telehealth to Reduce Avoidable Hospitalizations, Home Telehealth WebEx 1 of 4 Introduction, Home Telehealth WebEx 2 of 4 Phone Monitoring, Introduction of Home Telehealth for Home Health Aides, and Nuts and Bolts of Home Telehealth Reference 2005.

**Faculty:** Describe your knowledge and expertise in this topic area

Misty Kevech has been a Registered Nurse for over 27 years, including 22 years in home care. Ten years of her experience has been in Quality Improvement. Misty also is credentialed with Certified OASIS – Clinical (COS-C), which assists in educating on outcome measures. Misty has additional degrees of BS Ed in Public Nursing (California University of

Pennsylvania) and MS in Leadership with an emphasis on Training and Development (Carlo College) to assist with adult education. She has been employed by Quality Insights of Pennsylvania for one year working with home care agencies to improve quality outcomes. ACH, Ready, Aim, Improve Learning Session #3 – Works with home health agencies in Pennsylvania with development, implementation and evaluation of plans of actions to improve quality outcome measures. Misty also educates the agencies on strategies and best practices. SBAR – Participated in the three part series by IHI on SBAR. Telehealth – Planned and developed previous telehealth WebEx educational activities: Home Telehealth to Reduce Avoidable Hospitalizations, Home Telehealth WebEx 1 of 4 Introduction, Home Telehealth WebEx 2 of 4 Phone Monitoring, Introduction of Home Telehealth for Home Health Aides, and Nuts and Bolts of Home Telehealth Reference 2005.

### **Vested Interests of Faculty**

Having an interest in an organization does not prevent a speaker from making a presentation, but the audience must be informed of this relationship prior to the start of the activity. (If the applicant already has special forms to identify this, it does not need to be repeated on this biographical data form. Include the applicant's copy of the completed forms declaring vested interest.)

I recognize that I must follow all guidelines and criteria regarding vested interest. Any real or perceived conflict of interest for a conference participant must be disclosed. For this purpose a real or apparent conflict of interest is defined as having a significant financial interest in a product to be discussed directly or indirectly during the presentation; being or having been an employee of a company with such financial interest and/or having had substantial research support by an industry to study the product to be discussed at the presentation.

I have no real or perceived conflicts of interest that relate to this presentation

I have the following real or perceived conflicts of interest that relate to this presentation

# Eve Esslinger's Biographical Data Form

**This Individual is:** (check all that apply)

- Administratively Responsible Person
- Planning Committee Member
- Presenter/Content Specialist

## ***BIOGRAPHICAL DATA FORM***

Instructions: Make as many copies of this form as necessary to provide the required information documenting adherence to the criteria. **Do not** send curriculum vitae. Form must be typed or word-processed.

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Project Manager

**Employer:**

Quality Insights of Pennsylvania

**Planners:**

Describe your professional qualifications and familiarity with the target audience

Registered Nurse for 25 years. Masters in E.C. Education. 14 years working in Quality Improvement and Staff Development in Home Health. Presently working for Quality Insights of Pennsylvania (for 3 years) and 1½ years as Project Manager for Home Health Quality Improvement Support Center. Currently work with home health agencies and other quality improvement organizations to provide resources and guidance with quality improvement.

**Faculty:**

As above

## **Vested Interests of Faculty**

Having an interest in an organization does not prevent a speaker from making a presentation, but the audience must be informed of this relationship prior to the start of the activity. (If the applicant already has special forms to identify this, it does not need to be repeated on this biographical data form. Include the applicant's copy of the completed forms declaring vested interest.)

I recognize that I must follow all guidelines and criteria regarding vested interest. Any real or perceived conflict of interest for a conference participant must be disclosed. For this purpose a real or apparent conflict of interest is defined as having a significant financial interest in a product to be discussed directly or indirectly during the presentation; being or having been an employee of a company with such financial interest and/or having had substantial research support by an industry to study the product to be discussed at the presentation.

- I have no real or perceived conflicts of interest that relate to this presentation
- I have the following real or perceived conflicts of interest that relate to this presentation:

# Bonnie Kern's Biographical Data Form

**This individual is:** (Check all that apply)

- Administratively Responsible Person
- Planning Committee Member
- Presenter/Content Specialist

## BIOGRAPHICAL DATA FORM

**Instructions:** Make as many copies of this form as necessary to provide the required information, documenting adherence to the criteria. **Do not** send curriculum vitae. Form must be typed or word-processed.

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**Planners:** Describe your professional qualifications and familiarity with the target audience ACH, Ready, Aim, Improve Learning Session #3 - I have been in health care for over 25 years and over 15 years have been in home care. I have been employed with Quality Insights for 4 years working with home care agencies to improve their quality outcomes. I utilize the clinical data to help agencies plan their strategies for improvement. I am the lead person at Quality Insights related to Home Telehealth. I helped developed the Home Telehealth Reference 2005 manual that CMS is using as their official guide for home telehealth. I also was the primary editor for the Home Telehealth Reference 2006/2007 manual.

**Faculty:** Describe your knowledge and expertise in this topic area  
Same as above.

### Vested Interests of Faculty

Having an interest in an organization does not prevent a speaker from making a presentation, but the audience must be informed of this relationship prior to the start of the activity. (If the applicant already has special forms to identify this, it does not need to be repeated on this biographical data form. Include the applicant's copy of the completed forms declaring vested interest.)

I recognize that I must follow all guidelines and criteria regarding vested interest. Any real or perceived conflict of interest for a conference participant must be disclosed. For this purpose a real or apparent conflict of interest is defined as having a significant financial interest in a product to be discussed directly or indirectly during the presentation; being or having been an employee of a company with such financial interest and/or having had substantial research support by an industry to study the product to be discussed at the presentation.

- I have no real or perceived conflicts of interest that relate to this presentation
- I have the following real or perceived conflicts of interest that relate to this presentation

## Technical Expert Panel

The Home Health Quality Improvement Organization Support Center (HHQIOSC) would like to thank everyone who contributed to the **Best Practice Intervention Package – Fall Prevention**. We would also like to acknowledge the following individuals and organizations for their contributions as our Technical Expert Panel.

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## Special Acknowledgements

**Missouri Alliance for Home Care**

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***Mary Calys, PT, MS, BSW***, Consultant

**Christiana Care VNS, Delaware**

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## HHQIOSC Team

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## Best Practice: Fall Prevention

# Therapist Track



This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.465. App. 10/07.



## Therapist Track

This best practice intervention package is designed to educate and support therapists in the priorities necessary for a comprehensive home health fall prevention program that will support reducing avoidable acute care hospitalizations.

### Objectives

After completing the activities included in the Therapist Track of this **Best Practice Intervention Package – Fall Prevention**, the learner will be able to:

1. Recognize the need for more than just a fall risk assessment for an effective home health fall prevention program.
2. Describe how fall prevention will support reducing avoidable acute care hospitalizations.
3. Describe two therapy actions that will ensure optimal fall prevention for staff, patients and caregivers.

Complete the following activities:

	<b>Activity</b>	<b>Location</b>	<b>Estimated Time</b>
<input type="checkbox"/>	Read the Therapists Guide to Fall Prevention and Accurately Assessing Orthostatic Hypotension. Review the Fall Risk Assessment tool	<a href="#">Page 53</a>	20 minutes
<input type="checkbox"/>	Listen to podcast	<a href="#">Page 57</a>	15 minutes
<input type="checkbox"/>	Watch the Timed Up and Go video PowerPoint	<a href="#">Page 57</a>	25 minutes
<input type="checkbox"/>	<b>OR</b>		<b>OR</b>
<input type="checkbox"/>	Read the Timed Up and Go instructions and practice performing it with a co-worker	<a href="#">Page 58</a>	25 minutes
<input type="checkbox"/>	Read Examples of Excellence	<a href="#">Page 59</a>	10 minutes
<input type="checkbox"/>	<b>Complete the therapy post-test online for free certificate of participation</b>	<b>See link below</b>	10 minutes
	<b>Total time for completion</b>		<b>80 minutes</b>



**Therapists (PT, PTA, OT, COTA, & SLP):** Apply for a certificate of attendance. **Complete evaluation/post-test online at:**

<http://www.zoomerang.com/survey.zgi?p=WEB2273GNEBEWN>

# Therapist's Guide to Fall Prevention

## Definition:



- **Fall** - “An unintentional change in position resulting in coming to rest on the ground or at a lower level” (Missouri Alliance for Home Care).
- **Fall Prevention** – “A strategy that uses specific interventions to help specific patients or all patients avoid the risks of falling in an effort to reduce hospitalizations” (Briggs National Quality Improvement/Hospitalization Reduction Study, 2006).

## Significance:



- **More than one third** of adults 65 and older fall each year in the United States [CDC].
  - After age 75 the incidence increases [AGS]
- Of those that fall, one in forty will be hospitalized. Of those hospitalized, only half will be alive at the end of the year [Kane et. al., 1994].
- Falls, even without injury, often cause a person to develop a fear of falling, which, in turn, limits their activity [CDC].
- In 2003, there were more than **309,500** hospital admissions for hip fractures [NCHS 2006].

CDC – Centers for Disease Control and Prevention

AGS – American Geriatrics Society

NCHS – National Center for Health Statistics

## How therapists can promote a successful fall prevention program:



1. Be a role model for fall prevention in daily practice
2. Collaborate with nurses on OASIS accuracy to capture fall risk
3. Be a resource for all staff on fall prevention
4. Include agency's fall prevention program in any marketing opportunities with referral sources, physicians and community
5. Assist with developing, evaluating and modifying the agency fall prevention program on a regular basis
6. Include fall risk and prevention interventions in case conferences
7. Offer to participate in staff in-services to instruct in fall prevention program



The **key to a successful fall prevention program** is moving beyond responding to witnessed or non-witnessed falls to **focus on fall prevention**. Prevention not only incorporates an assessment of risk for falls, but also promotes a **proactive approach to fall prevention** rather than reacting to individual falls.



# Fall Prevention Program

## Risk Assessment:

Your agency may already have a fall risk assessment that may be:

1. Paper based
2. OASIS-based
3. Included in hospitalization risk assessment
4. Integrated into your point of care programs

The high-risk patients must be identified for falls, just like the high-risk patients for hospitalization, so that clinicians can implement appropriate preventative interventions.

On page 56 there is a sample Fall Risk Assessment.

Review the tool and consider the following questions:

- Does your agency's current risk assessment capture all of the same information?
- Are there other risk factors you should be assessing?
- Should you perform a Timed Up & Go test? (see page 58)

## Potential Interventions for Fall Prevention:

- Complete home safety evaluation and reduce hazards in the home including:
  - Inadequate lighting
  - Throw rugs, loose flooring
  - Clutter
  - Extension cords
  - Oxygen tubing
  - Pet(s)
- Request nursing referral for medication management
- Request physical therapy evaluation and treatment for balance training, strengthening and gait training
- Assess need for or adjustments with durable medical equipment and/or assistive devices
- Consider wheelchair and bed alarms, if applicable
- Encourage adequate footwear
- Seek occupational therapy evaluation and instruction for management of ADL/IADLs
- Referral for Home health aide for assistance with bathing, if unsteady
- Medical social worker evaluation for social support and resources for glasses/hearing aids funding
- Utilize community based organizations as a valuable resource
- Encourage patient to participate in a maintenance exercise program, adapt to patient ability (e.g. Sit & Be Fit – TV exercise for seniors)
- Encourage patient to have an annual vision evaluation (minimum)
- Consider if fall(s) are a result of a cardiovascular problem and contact physician for further intervention (orthostatic hypotension or cardiac arrhythmias)
- Encourage adequate hydration and nutrition and make appropriate referral

## Some fall risk factors...

- Age (>65 year old)
- Mental impairments (e.g. dementia)
- Female gender
- Past history of a fall
- Weakness in the feet or legs
- Walking problems
- Foot disorders
- Problems with hearing or vision
- Balance problems
- Low vitamin D levels
- Medications (especially drugs used for psychiatric or mood problems)
- Arthritis
- Parkinson's disease

Adapted from

<http://www.healthinaging.org/agingintheknow>



## Accurately Assessing Orthostatic Hypotension

### Recommendations for Assessment Procedure:

Follow agency-specific practice standard/policy and procedure, while using nursing judgment with assessment and evaluation of findings for intervention selection.

1. Explain procedure and reason for assessment to patient/caregiver—instruct patient to report any symptoms of dizziness, lightheadedness or faintness at any time during the assessment.
2. Obtain **supine** blood pressure (BP) and heart rate (HR) measurement once patient has been in supine position for **5 minutes**.
3. Assist the patient to a safe **sitting** position with legs dangling over the edge of bed/couch, wait one minute then obtain and document BP, HR and patient symptoms.
4. If the patient tolerates position change with no orthostatic hypotension and the patient is able to stand, assist patient to a **standing** position.
  - **Wait 1 - 2 minutes**, obtain BP/HR then document BP, HR and patient symptoms—if orthostatic changes are present, return patient to a safe, comfortable position
  - Intervene according to agency protocol and clinical indications
5. Evaluate assessment findings and continue according to agency protocol and clinical indications.

### Interventions for Orthostatic Hypotension May Include but are Not Limited to:

1. Notify physician when assessment indicates orthostatic hypotension (ensure that medication reconciliation has been completed)
2. Instruct patient to sit at the edge of bed or couch for **30-60 seconds** when moving from a lying to standing position
3. Instruct patient to walk in place for **1 minute** after standing before walking away (e.g., avoid rushing to answer phone or door bell)
4. Instruct patient NOT to bend over at the waist to reach for something low
5. Instruct on not rising too quickly after a meal (meals can induce hypotension)
6. Inform interdisciplinary team members to adjust treatment plan accordingly with inclusion of fall prevention interventions
7. Review medications and obtain orders for lab work to assess for volume depletion





## Fall Prevention Multi-Media Activities Podcast\* (Audio Recording)

### Fall Prevention Podcast (Audio Recording) Instructions:

Listen to the podcast (audio recording) to learn more about reducing avoidable acute care hospitalizations with fall prevention from **Christiana Care VNA in Delaware**. Gale Bucher, RN, MSN, Performance Management Coordinator and Pam Szczerba, PT, MPT, Therapy Consultant will share key points on how to successfully implement a fall prevention program.

### Fall Prevention Podcast

- 15 minute podcast (audio recording)
- Podcast (audio recordings) link is located at:  
[http://www.homehealthquality.org/hh/hha/interventionpackages/falls\\_prevention.aspx](http://www.homehealthquality.org/hh/hha/interventionpackages/falls_prevention.aspx)

There are several ways to listen to the podcast (audio recording):

- Visit the link above and listen directly through the Web site.
- Download the podcast (audio recording) by right clicking on the audio file and selecting “Save Target As ...” This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can burn the audio file to a CD or download to a MP3 player.

\*A podcast is a digital media file, often an audio recording, placed on the Internet and made available to the listener on their home computer or personal digital recording device for convenience. There is no change from previous references to “audio recordings” except the name. You may continue to download and listen to recordings as you have in previous months.



## Video PowerPoint Timed Up and Go

The **Time Up and Go PowerPoint** includes video with Mary Calys, PT, MS, BSW, Consultant from Missouri Alliance for Home Care. Mary provides instruction and demonstrations of the Timed Up and Go screening, based upon the APTA’s Balance and Fall Awareness Event Instruction Booklet for Physical Therapists, (1999).

Video PowerPoint link is located at [www.homehealthquality.org](http://www.homehealthquality.org) with the [Fall Prevention Best Practice Intervention Package, under Video PowerPoint](#)

View the PowerPoint on your personal computer or download to use as a presentation:

- Right click on the **Timed Up and Go** PowerPoint, click on *Save Target as* and save to your computer
- Open **Timed Up and Go** PowerPoint
  - Click on Slide Show, View Slide Show
  - Click on screen to start



# TIMED UP AND GO Screening Tool



**Purpose:** Simple **screening tool** to identify elderly patients **at risk for falls**

**Preparation:** Ask patient if he or she wears glasses or is experiencing visual problems. Patient should **wear eyeglasses** and **use assistive devices** (cane, walker, etc.) if applicable.

**Explain or demonstrate** the test before proceeding.

1. Ask the patient to sit comfortably in the chair
2. Ask patient to rise by stating, “Ready, set, go” and begin timing
3. If patient experiences dizziness upon rising, they may momentarily stand still to resolve
4. Patient walks toward point of destination (10 foot walk)
5. After reaching point of destination, patient turns around and returns to chair
6. When patient sits down, stop timing
7. Patient is scored according to the time in seconds required to complete the entire task

TIME \_\_\_\_\_ Score \_\_\_\_\_

Score on a scale of 1 – 4	
1. Less than 10 seconds	High mobility
2. 10-19 seconds	Typical mobility
3. 20-29 seconds	Slower mobility
4. 30+ seconds	Diminished mobility

Use the Timed Up and Go score with hospitalization risk assessment findings and **clinical decision-making** to identify patients at-risk for falling. Observe the patient for the following as a part of the decision regarding patient risk for falls:

- Undue slowness
- Hesitancy
- Dizziness
- Abnormal movement of trunk or upper extremities
- Staggering or stumbling

Re-test the patients weekly to compare scores. This is an excellent way for ALL staff to have an objective measure that can be reviewed on a weekly basis to show improvement or lack of improvement.

Clinicians then must **select appropriate interventions** for fall prevention for patient (see page 54 for examples).

**Video PowerPoint available for demonstration of Timed Up and Go (see page 57)**  
Modified from the APTA’s Balance and Fall Awareness Event Instruction Booklet for Physical Therapists, copyright 1999, American Physical Therapy Association.



# Examples of Excellence

## Fall Reduction at Avera St. Luke's Home Health: The Collaboration Dance



Avera St. Luke's Home Health is a hospital-based home health agency located in rural Aberdeen, South Dakota with approximately 500 episodes of care annually. The agency successfully reduced patients' risk for falls in the home by implementing a fall reduction program that included:

- Multidisciplinary collaboration
- New forms
- Assessment
- Screening tools
- Patient education
- Performance improvement monitoring

### Problem Identification

In the autumn of 2005, Cindy Senger, Director of Home Health, Hospice, Palliative Care and Respiratory Home Care, reported that Avera noticed a 23 percent increase in the fall rate for skilled home health patients as part of an annual summative evaluation. Reviewing these data in conjunction with the JCAHO 2006 Home Care National Patient Safety Goal to "reduce the risk of patient harm from falls," agency staff began the multidisciplinary collaborative dance to reduce home health patients' fall risk.

### Creating a Fall Prevention Committee

To address the issue, the agency formed a falls committee consisting of Jackie Jund, RN, Kim Kram, Physical Therapist and Carla Van Dyke, Nurse Manager, who also serves as the intake manager for all new cases, sitting in on discharge meetings with hospital staff. The goals of the committee were to: (1) reduce fall rate of skilled home health patients by 10 percent in the first year by June 2006 and (2) decrease the fall risk severity grade, calculated by the updated clinical risk fall screening tool completed collaboratively by nursing and therapy by 0.5 percent at the time of discharge in 75 percent of the skilled home health patients.

### Change Determination

The Avera St. Luke's fall prevention committee collaborated with the South Dakota QIO to identify fall prevention best practices. Once best practices were determined, the fall prevention committee and agency staff:

- Expanded and updated the fall risk screening tool and increased its use by requiring it be completed at: admission, recertification, resumption of care and discharge of all skilled patients
- Developed a post-fall audit tool to be completed following each fall for a skilled home health patient – both witnessed and un-witnessed falls
- Developed PT consultation criteria, and/or if the fall was related to incontinence, the PT consult included an incontinence treatment evaluation. Performance improvement activity included the development of an incontinence pathway and therapy treatment interventions
- Developed pharmacy consultation criteria (The pharmacist determines if medication may

- have contributed to the fall. Pharmacy consultation occurs by phone or face-to-face during weekly patient team conference.)
- Developed criteria that requires documentation in the record to reflect additional post-fall patient/caregiver education concerning safety and fall risk
  - Developed a performance improvement study related to fall risk for 2006-2007

#### **Improvement Strategies**

- Utilized research done by Avera St. Luke's falls committee to select best practice interventions for fall risk program development
- Revised the fall risk screening tool multiple times to validate the tool
- Conducted multiple educational sessions to ensure staff understood dance steps for: using the screening tool, achieving desired outcomes, completing patient record documentation and using additional patient education tools
- Modified outcomes to ensure reliability of the screening tool indicators
- Adapted Avera St. Luke's hospital fall risk patient education for home care

#### **Improvement Challenges**

The primary challenge was achieving full engagement of the therapy and nursing staff in the dance. This achievement is an example of pure musical multidisciplinary collaboration to benefit patient care. The second challenge has been maintaining continuous staff buy-in and educating all staff on the steps, process and progress made in attaining the desired outcomes.

#### **Measurable Results**

Baseline data obtained prior to implementation of the fall risk program showed: the fall risk screening tool was inconsistently used at the desired time points, used correctly on admission only 50 percent of the time and 1 percent of the time at discharge with no documentation of the level of fall risk at the time patient was discharged. The tool was not valid in measuring patients' risk for falls (it was evident staff were not dancing to the music).

Audits were completed for four quarters from 4/06 – 3/07 to measure the fall risk severity weight calculated by the clinical risk profile to result in a .5 decrease at the time of discharge in 75 percent of all skilled home health patients:

- 1st Quarter: clinical risk profile weight decreased by .4 in 44 percent of all skilled patients
- 2nd Quarter: clinical risk profile weight decreased by .61 in 50 percent of the skilled patients
- 3rd Quarter: clinical risk profile weight decreased by .68 in 100 percent of the skilled patients
- 4th Quarter: clinical risk profile weight decreased by .73 in 60 percent of the skilled patients

Review of all falls data for FY 2005/2006 indicated a 32 percent decrease in the number of falls experienced by skilled home health patients.

#### **Collaboration: Strength of the Agency**

"Collaboration is a real strength of our agency," says Senger. "Nurses and PTs work together to provide the best care for the patients, and the disciplines are right in step with one another to reduce falls." A lot of informal discussion occurs about each patient among the PT, OT and RN staff whose offices are all very close together at the agency. "There's a real team spirit and participatory style. Our clinicians feel very good about the care they're giving our patients, and they take a stake in the performance improvement projects," reflects Senger. "These people are always looking to do something better. We all work together to make things better, and they are an integral part of our improvement process."

*\* Information and data provided by Cindy Senger, Avera St. Luke's Home Health*

# Visiting Nurses Association of Boston Drastically Lowers Emergent Care Rate Due to Falls



Fall prevention is not new for the Visiting Nurses Association (VNA) of Boston. This agency, one of the largest home health agencies in New England, has been proactive with an ongoing fall prevention program for years. However, for the past two years, the agency has intensified its approach by taking a closer look at what patients are considered “high risk” for a fall.

Unlike many home health agencies, VNA of Boston considers every patient at risk for a fall. While the agency does use a risk assessment tool to identify how high the patient’s risk might be, all patients receive education and monitoring to help protect them from a possible fall at home.

VNA of Boston’s fall risk assessment tool is also different than many other agencies. While many assessment tools include ten or fewer common fall risk factors, VNA of Boston’s includes twelve. The agency felt it was important to include postural hypotension and fear of falling on its tool. Fall intervention is then provided on a “sliding scale” – the more risk factors a patient has, the more interventions the agency provides.

“Because all of our patients are home bound, have some type of health concern and most are elderly, all of them receive basic fall prevention education upon admission to our agency,” shared Carson Reinart, PT, DPT and Rehabilitation Program Developer and Clinical Educator at VNA of Boston.

## **Interventions Admission**

Upon admission, the admitting clinician completes the fall assessment and determines the patient’s fall risk rate. The clinician also provides each patient with a booklet, Preventing Slips and Trips in the Home, and reviews five core fall prevention areas that research has found to be most critical in preventing falls in the home. The admitting clinician distributes the booklet to the patient and any caregivers. Then, depending on the patient’s identified fall risks, interventions may be recommended. For example, if the patient only has one risk factor he/she would receive the education booklet and a follow-up discussion upon the next visit. If the patient has two or more risk factors, he/she would receive an

intervention that coincides with that risk factor – such as making a referral to physical therapy if the patient has impaired functional mobility.

### **Core Areas for Preventing Falls in the Home**

1. Physical Activity
2. Stay hydrated and eat properly
3. Get an annual vision check
4. Annually review medications and doses
5. Keep the home environment safe and free of hazards

### **Outcomes**

Prior to the agency enhancing its program and considering each patient at risk, VNA of Boston's 2005 emergent care, due to falls, peaked at 2.9 percent. After the agency implemented the program in 2006 with two pilot teams, which had the highest rates, there was a decrease in the rate to 1.42 percent in just the first half of the year. By the end of 2006, the rate dropped even lower to 1.20 percent in one of the pilot teams.

### **Success Attributions**

The agency attributes its success to partnerships and extensive research. VNA of Boston participates in the Missouri Alliance of Home Care project, which provides benchmarking reports and peer comparisons. See the leadership section of the Best Practice Intervention Package for more information.

As for advice to other agencies seeking to make this same effort, the team at VNA of Boston says it is a matter of awareness – falls can be prevented. The elderly are capable of improving balance and increasing the safety of their environments, in addition to managing vision or medications properly. “There are so many areas that you can assess and address – not just one,” says Reinart. “Deal with as many as possible to reduce the risk of falling.”

*Data in this article was provided by Carson Reinart at VNA of Boston.*



Clinician name: \_\_\_\_\_

Date: \_\_\_\_\_



## Therapist Post-Test Fall Prevention



[All therapists, including OTAs and PTAs can apply for a certificate of attendance to use towards continuing education for XX continuing education hours – follow directions on page 53.](#)

Directions: Choose the ONE BEST response to the following questions. Circle the answer that identifies the ONE BEST response.

### Therapist

1. Fall prevention is more than just completing a fall risk assessment. Patient-specific interventions are utilized to assist with decreasing the risk of falling and preventing harm.
  - A. True
  - B. False
2. Falls can affect the following **except**:
  - A. Increasing unnecessary acute care hospitalizations
  - B. Increasing harm to patients
  - C. Decreasing the quality of life for patients
  - D. Increasing the fear of falling
  - E. Increasing medical insurance premiums
3. Fall prevention may reduce avoidable acute care hospitalizations by the following **except**:
  - A. Fall risk assessments will identify those patients at-risk
  - B. Preventative interventions can be implemented prior to falls
  - C. Fitting everyone with a standard walker
  - D. Early referrals to nursing when medication issues are identified
4. Therapists cannot manage fall prevention independently. Therapists must collaborate with interdisciplinary team members **and** with the patient/caregiver to be successful with fall prevention.
  - A. True
  - B. False
5. Each of the following is a potential fall prevention intervention that an agency can utilize with patients and caregivers **except**:
  - A. Performing a fall risk assessment on all patients
  - B. Obtaining appropriate interdisciplinary referrals
  - C. Encouraging age-specific immunizations
  - D. Assessing patients' at-risk status with a simple technique like *Timed Up and Go*
  - E. Providing verbal and written fall prevention education to patients and caregivers

**Answers to Post-Test are located in the Leadership Section page 35.**