



Best Practice: Fall Prevention

Leadership 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.

Leadership Section Objectives

Objectives

After completing the activities included in the Leadership Section of this **Best Practice Intervention Package – Fall Prevention**, the leader will be able to:

1. Recognize the key priorities of a fall prevention program.
2. Recognize the potential impact of the **lack** of a fall prevention program on an agency’s acute care hospitalization rate.
3. Initiate and/or enhance a structured fall prevention program.

How to Use This Package

Review Fall Prevention Concepts

- Four C’s Approach to Evaluating and Developing
- Four Priorities of a Fall Prevention Program
- Implementation of a Fall Prevention Program

Complete Fall Prevention Agency Assessment

Select Leadership Action Items

Review Fall Prevention Tools for Implementation

- Fall Risk Assessment Form
- Patient/Caregiver Education Sheet
- Timed Up and Go Screening Tool
- Accurately Assessing Orthostatic Hypotension Education Guide
- Fall Report Form



Establish Leadership Action Plan

Share Connection Pages with Appropriate Staff

Place Fall Prevention Posters in Strategic Places in Office

Distribute Discipline-Specific Care Tracks

Encourage Completion of Care Track Activities:

	Review Fall Risk Assessment	Review Fall Prevention Guide	Review Assessing Orthostatic Hypotension	Listen to Podcast	Complete Timed Up & Go Activity	Read Examples of Excellence	Complete scenario exercises	Complete Post Test for certificate
Nurse	X	X	X	X	X	X		X
Therapist	X	X	X	X	X	X		X
MSW	X	X		X				X
Aide		X		X			X	X

Fall Prevention

Best Practice Intervention Package

FALLS are among the most common and serious problems facing the elderly. Falling is associated with:

- Mortality
- Morbidity
- Reduced function
- Premature nursing home admissions

Journal of the American Geriatric Society (AGS)
49: 664–672, 2001

A fall is defined as “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 is a major component of patient safety. The Institute of Medicine (IOM), 2003, stated that patient safety is defined as the prevention of harm to patients, where harm can occur through errors of commission and omission.

No longer can health care providers just respond to patient incidents by investigating the reason for the fall and responding to prevent injuries. Decisive and progressive health care providers must search for a proactive approach to patient safety, including patient fall prevention interventions.

Consider the following:

- **More than one third** of adults 65 and older fall each year in the United States [CDC].
 - After age 75 the incidence increases [AGS].
- More than 30 percent of community-dwelling older adults fall at least once each year; of the 30 percent, half do so repeatedly [AGS].
- Of those who 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].

CDC – Centers for Disease Control and Prevention

AGS – American Geriatrics Society

NCHS – National Center for Health Statistics

Significance:

- Fall-related injuries recently accounted for 6 percent of all medical expenditures for people age 65 and older in the United States [AGS].
- In 2000 alone, direct medical costs totaled \$179 million for fatal and \$19 billion for nonfatal fall injuries [CDC].
- Falls, even without injury, often cause a person to develop a **fear of falling**, which, in turn, limits their activity [CDC] and predisposes them to repetitive falls.
- In 1998 a study found that people 72 and older had an average health care cost of \$19,440 for a fall injury (includes everything except doctor services) [CDC].

Direct costs do not account for the long-term consequences of these injuries, such as **functional disability, decreased productivity and/or reduced quality of life.**

Potential Impact: Acute Care Hospitalizations

- In 2003, there were more than **309,500 hospital admissions** for hip fractures [NCHS 2006].
- In 2000, nearly two-thirds of the costs for nonfatal fall injuries were for those needing hospitalization [CDC].
- One study found that falls were a major reason for 40 percent of nursing home admissions [AGS].



STOP!

Don't put your patients and your agency at risk!!!

Consequences of not preventing falls...

- Patients experiencing hip fractures and other disabling injuries
- Patients suffering traumatic brain injuries with permanent cognitive impairment
- Patients having severe loss of independence
- Increasing need for more caregivers and increasing burden on current caregiver
- Premature admissions to nursing homes
- Patient death

Detecting a history of falls and performing a fall-related assessment is likely to reduce the future probability of falls when coupled with patient-centered intervention.

(Guideline for the Prevention of Falls in Older Persons – 2001,
American Geriatrics Society, British Geriatrics Society, and American Academy of
Orthopaedic Surgeons Panel on Fall Prevention)

“Community based organization fall prevention programs can be a valuable resource. Think of them for your higher functioning clients, or those who do not need the skills of physical therapists. An individualized routine of calisthenics is often the most physical and cost-effective. Make referrals to the community-based organizations when discharging patients who are still at risk for falling.”

Maureen Parent
Fall Prevention Coordinator, LFC
LIFE Elder Care, Inc.

Developing a Fall Prevention Program

Fall Prevention Definition

Fall prevention in the home health setting is defined as 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).

Consistent
Cross Disciplines
Coordinated
Culture



While it is known that fall injuries are among the most frequent and preventable sources of **morbidity**, **health care utilization** and **functional decline** among older persons, little attention has been given to their **prevention** in clinical practice.

The Four **C's** approach will provide ownership to the agency's leadership with a model to evaluate current fall prevention processes and identify program development and/or enhancements.

Consistent – Agency employs fall prevention interventions with all patients who are targeted to be at risk for falling.

Cross Disciplines – The fall prevention program has an **interdisciplinary** approach. It combines all disciplines in planning, developing and implementing the program in addition to actual interventions.

Coordinated – An effective fall prevention program is well coordinated from **SOC/ROC through patient discharge**. Potential patient falls are prevented and patients and family members/caregivers are educated to continue fall prevention strategies independently in their own home after discharge from home care.

Culture – Agency leadership moves the agency from a culture of responding to patient incidents to a culture of **prevention** of falls and harm!

Intervention programs are most effective when they are designed to reach those at **greatest risk** of falling (Tinetti, 1994).

Also see the Continuum of Care Connection on page 33.

Fall Prevention Program Priorities

A fall prevention program has **four priorities**:

- 1. Fall Risk Assessment**
- 2. Proactive Fall Interventions**
- 3. Patient and Caregiver Education**
- 4. Evaluation of Fall Prevention Program**

Priority #1: Fall Risk Assessment

- ❑ There are many risk factors for falling and an **increased number of risk factors heighten the risk of falling.**
- ❑ Suggestions related to Fall Risk Assessment:
 - Use at SOC/ROC and with change in patient status
 - Consider repeating at recertification and discharge
 - May incorporate with hospitalization risk assessment or baseline assessment
 - Keep it simple
- ❑ Select a Fall Risk Assessment tool that is home care specific:
 - Evaluate your current tool
 - See sample **Fall Risk Assessment Screening Tool** from Missouri Alliance for Home Care (page 23)
 - See **sample Fall Risk Assessment** by Christiana Care VNA featured in the March 2007 Home Healthcare Nurse Journal (see abstract next page)
 - Use another tested fall prevention assessment tool, but select one that is home care appropriate
- ❑ Staff education alone will not prevent falls.
 - Improving staff **understanding of the importance of falls** is essential for ownership of fall prevention program.
- ❑ Use the Accurately Assessing Orthostatic Hypotension Education Guide (page 27) for orientation and annual staff education/competencies.

Some fall risk factors...

- Age (>65 years)
- 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/aginginthenow>

“The assessor should be astute in asking questions clearly defined by what they mean by a fall. Include words like ‘slipped’ or ‘tripped’ when asking the patient if the patient has fallen. Patients also may not disclose their fall history in fear of being placed in a nursing home.”

Vickie Leone, MSN, RN, CHCE
Executive Director, Fayette Home Care

Fall Prevention Program Priorities (cont.)



A Comprehensive Fall Prevention Program for Assessment, Interventions and Referral

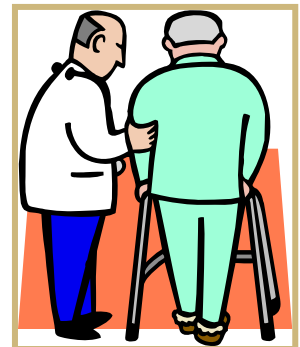
Bucher, G., Szczerba, P., & Curtin, M. (2007). A comprehensive fall prevention program for assessment, interventions and referral. *Home Healthcare Nurse*, 25, 174 – 183.

Christiana Care Visiting Nurse Association (VNA) describes the development of its fall prevention program including the development of a fall risk assessment form that directly associates with the OASIS Mo code items. The agency also shares the following tools: a **fall prevention plan**, a **post-fall assessment** and an **intervention algorithm**.

Priority #2: Proactive Fall Prevention Interventions

Patients identified as at risk must have appropriate proactive interventions to prevent falls. Home health agencies have debated the responsibilities of reporting ‘witnessed’ versus ‘non-witnessed’ falls. Certainly, agencies must continue to evaluate causes and outcomes from individual patient falls.

However, the key to a 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 **preventing** all falls rather than **reacting** to individual falls.



Target treatment for those at risk - NOT every patient

“Coaching the patient and family on reporting changes in the patient’s condition and medications to the health care provider is important to the ongoing assessment for identifying fall potential. Coaching is also vital for patients and caregivers to take control of their health and recovery process and prevent avoidable issues, such as falls.”

Pamela Patterson, RN, BSN
Community Resource Program Manager, Pittsburgh, PA

Potential Fall Interventions

- ❑ Complete a home safety evaluation and reduce hazards in the home, including:
 - Inadequate lighting
 - Throw rugs, loose flooring
 - Clutter
 - Pet(s)
 - Extension cords
 - Oxygen tubing
- ❑ Medication management
- ❑ Request physical therapy evaluation and treatment for balance training, strengthening and gait training
- ❑ Determine need for assistive device with ambulation
- ❑ Encourage adequate footwear
- ❑ Seek occupational therapy evaluation and instruction for management of ADL/IADLs and vision disabilities
- ❑ Refer to home health aide for assistance with risky functional activities (bathing, walking)
- ❑ Refer to medical social worker evaluation for social support
- ❑ Utilize community based organizations as a valuable resource
- ❑ Encourage patient to participate in a home/routine 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
- ❑ Request nutrition/hydration evaluation referral

Physical activity programs, particularly those emphasizing balance and lower extremity strengthening, are associated with a 10-20 percent reduction in falls [AGS].



Medications:

- ❑ A crucial component of any fall evaluation is an assessment of the patient's medications.
- ❑ Some medications that have been associated with an increased risk of causing falls include: psychotropic medications, benzodiazepines, sedatives, antidepressants, antipsychotics, narcotics, other pain medications, antihistamines and diabetic medication.
- ❑ In addition to reviewing the medication list, it is important to find out which of these are actually being taken and whether any over the counter (OTC) or herbal preparations are being used.
- ❑ Seemingly benign medications such as Benadryl® can adversely affect the elderly because of their anticholinergic properties.
- ❑ Diuretics and laxatives can cause falls because patients may hurry to the bathroom.
- ❑ When taking two or more medications in combination, the side effects may be enhanced.

Beers Criteria

The Beers Criteria is a list of potentially inappropriate medications for use in older adults independent of diagnoses or conditions. It indicates specific concerns and assigns a high or low severity rating. Located at www.medqic.org. Under: *Home Health, Oral Medications, Tools.*

Priority #3: Patient and Caregiver Education



Leadership must designate a team to determine the specific patient and caregiver educational materials to be used with the agency population. The awareness/educational materials and practices need to be consistent, patient specific and interdisciplinary, including the home health aides. Materials can include patient/caregiver teaching sheets, home self-assessment tools, etc.

In addition to educational materials, the clinicians need to make sure the patient and caregivers are aware that the patient is at risk for falling, what potential interventions are available to reduce that risk and their specific role in fall prevention.

Priority #4: Evaluation of Fall Prevention Program



For a fall prevention program to be successful, evaluation and monitoring are essential. A **fall report form** provides information regarding actual fall occurrences. A sample fall report form is provided on page 28 from the Missouri Alliance for Home Care (MAHC). It measures the accuracy of the fall risk assessment in predicting potential fallers, timely referral to appropriate disciplines and possible gaps in the provision of best practices.

For agencies that are registered participants in the *Home Care Fall Reduction Initiative* (more information on next page), their data is utilized to create a quarterly benchmark analysis and indicate fall trends. Trends are categorized by demographics to allow agencies to make meaningful comparisons and identify internal processes requiring improvement.

Although the fall risk assessment and fall report tools are available on the MAHC Web site for use by any agency, access to the quarterly benchmark analysis is possible only with full participation in the initiative. **Benchmarking is fundamental to improving fall-related outcomes** and attaining P4P incentives. It provides the road map by which agencies can impact home care falls and achieve excellence in patient care. See the next page for more information on how to join this initiative for benchmarking capabilities.

Assessing and benchmarking falls in home health poses unique obstacles due to an uncontrolled environment where falls are frequently unmonitored, unreported and untreated. Many home health agencies have spent countless hours and staff resources developing systematic protocols to promote fall reduction and decrease hospitalization rates. Although these protocols may be effective at an agency level, combining data from multiple agencies for the purpose of benchmarking trends is a challenging endeavor.

Home Care Fall Reduction National Initiative – Validating Best Practices/Benchmarking Opportunities



Missouri Alliance for Home Care (MAHC) created a multi-disciplinary task force in 2003 to discuss the problem of falls in home care. Representatives from Missouri home care agencies gathered to explore how combining efforts and expertise could have an impact on falls on a larger scale. Over the next year, members compared various fall reduction strategies currently used by agencies throughout Missouri. An extensive literature search was conducted to identify core elements to predict fall risk and reduce fall occurrences in the home. The task force concurred on:

- Fall definition
- 10-item fall risk assessment
- Fall report
- Quarterly benchmark analysis

The program was piloted for a period of three months and further refined. In early 2004, the **Home Care Fall Reduction Initiative** was opened for statewide participation. The initial goals of this study were to:

1. Reduce falls in home care patients
2. Improve patient outcomes
3. Establish a baseline of falls in home care

From 2004 to 2006, the study successfully predicted patients who fell with **88 percent accuracy**. In the same time period, the average number of falls requiring emergent care decreased from 15.5 percent to 13.8 percent. The average fall rate for all agencies was 5.1 percent. Interest in the study grew with agencies from other states requesting the opportunity to participate. Currently, agencies from nine states submit falls data and receive quarterly benchmark statistics.

With increased participation, the dialogue between agencies and disciplines expanded. It became evident that a major concern was to streamline best practices for easy access and utilization. In 2006, a subcommittee was formed to select:

1. Validated tools and measures
2. Patient education materials
3. Recent research pertaining to the core elements of the fall risk assessment

Links to this information were created and made available to the public on the MAHC website.

For more information about or to join this project visit:
<http://www.homecaremissouri.org/index.cfm>

Quality Insights of Pennsylvania does not endorse any specific fall prevention program. Missouri Alliance's program is highlighted based upon being home care specific and their research findings.

Implementing a Fall Prevention Program

Interdisciplinary Approach

Research shows that the combination and interplay of multiple risk factors puts a person at higher risk for a fall. For this reason, falls should be the concern of everyone on the home care team. The fall risk assessment crosses the scope of practice for multiple disciplines. All clinical staff (professional and paraprofessional) should be educated to screen for potential fall risk. Education may occur as an annual competency, in-service or skills fair. Clinicians should be kept abreast of agency progress in reducing fall occurrences and related hospitalization rates. An ongoing dialogue regarding falls reduction is essential in keeping clinicians' senses keen to potential risks and encouraging best practices.

Implementation of Priorities

Priority #1: Fall Risk Assessment

- Incorporate standard assessment items
- Automate score if using point of care documentation
- Promote use of the assessment
- Educate staff to minimize variation in completing the assessment
- Encourage interdisciplinary collaboration to determine fall risk

Priority #2: Proactive Fall Interventions

- Link deficit or area of risk with appropriate interventions
- Incorporate interventions into care plan
- Automate point of care plans with interventions to promote program compliance and ease clinicians' documentation
- Post Fall Algorithm
 - Create or modify an algorithm to address interventions post-fall
 - Use within the first 72 hours of fall to minimize injury and prevent future falls
 - Review sample created by Christiana Care VNA included in the March 2007 *Home Healthcare Nurse Journal*

Post Fall Algorithm

Christiana Care VNA's **Post Fall Algorithm** is beneficial to guide clinicians in clarifying expectations on how to respond to a fall. The algorithm is divided into intervention paths for conscious and unconscious patients. Assessment for evidence of serious head, spine or internal injury leads to notification of key personnel in the health care system. It is important to identify patients taking anticoagulants or with bleeding disorders because they are at higher risk for serious injury. Additional actions include instructing the caregiver on medical follow-up, review of medications and circumstances contributing to the fall.

Implementing a Fall Prevention Program – cont.

Priority #3: Patient and Caregiver Education

Spanish

- Review current written patient education sheets; create or modify as needed
- Sample patient and caregiver education sheet on page 25
 - **Also available in Spanish** on www.homehealthquality.org
- Educate staff on patient education materials to provide a consistent message
- Include fall risk assessment and interventions with annual competencies and orientation (e.g., return demonstration of Timed Up and Go type screenings)
- Provide staff list of local community resources for patients
- Incorporate fall prevention interventions into discharge plan

Priority #4: Evaluation of Fall Prevention Program

- Evaluate all falls and determine if preventable
- Assess effectiveness of fall risk assessment tool
- Ascertain if algorithm and/or preventative interventions were utilized
- Verify if interdisciplinary and physician communication occurred
- Share progress on program outcomes and successes with staff
- Provide overview of fall prevention program to:
 - Hospital staff, including therapy department
 - Discharge planners
 - Physicians
 - Payers



Fall Prevention Rounds

Case conferences are a familiar forum for clinician collaboration. Consider taking this one step further and providing a forum to discuss fall prevention. Fall Prevention Rounds can promote discussion by asking clinicians to identify common reasons why patients fall, what interventions have been used and strategies that are most effective.

Team communication can promote:

- Earlier referrals to occupational therapy and physical therapy
- Matching of interventions with areas of risk and deficit
- Recognition of opportunities to fine tune the fall prevention program

“A comprehensive fall prevention program can generate successful patient outcomes and make a positive impact on the community you serve.”

Gale Bucher, RN, MSN, Performance Coordinator
Christiana Care VNA

Fall Prevention Agency Assessment



<i>Consistent:</i>	Yes	No
Does agency have a fall risk assessment?	<input type="checkbox"/>	<input type="checkbox"/>
Is the fall risk assessment addressed at SOC, ROC and with changes in patient status?	<input type="checkbox"/>	<input type="checkbox"/>
Does the fall risk assessment adequately identify patients who are at risk of falls? (i.e., are patients falling who were not identified as ‘at risk?’)	<input type="checkbox"/>	<input type="checkbox"/>
Does the fall risk assessment include targeted interventions ?	<input type="checkbox"/>	<input type="checkbox"/>
Does staff understand the necessity of completing a fall risk assessment and following through with targeted interventions?	<input type="checkbox"/>	<input type="checkbox"/>
Is monitoring (chart audits or patient interviews) completed to evaluate if fall risk assessment and interventions are used consistently?	<input type="checkbox"/>	<input type="checkbox"/>
Do managers meet with individuals who do not comply with the fall prevention program - either with risk-identification assessments or with implementing interventions?	<input type="checkbox"/>	<input type="checkbox"/>
Are patient falls evaluated to see if the patient was identified as at risk and if interventions were appropriately implemented?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Coordinated:</i>	Yes	No
Are case conferences held for patients who: <ul style="list-style-type: none"> • Are at risk for falls? • Have fallen? 	<input type="checkbox"/>	<input type="checkbox"/>
Are success stories shared with all staff? (e.g., patients at risk for falls who were discharged without a fall, with improved strength and balance, and improved self-management)	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer annual mandatory fall prevention in-services to clinicians?	<input type="checkbox"/>	<input type="checkbox"/>
Are monitoring results shared with all staff? (Showing consistency of fall risk assessment and interventions)	<input type="checkbox"/>	<input type="checkbox"/>
Are adverse events shared with all staff?	<input type="checkbox"/>	<input type="checkbox"/>
Are patient falls tracked for trending and evaluation of causes?	<input type="checkbox"/>	<input type="checkbox"/>
Are underlying causes for falls considered? (e.g., syncope could be cardiovascular related)	<input type="checkbox"/>	<input type="checkbox"/>

Agency Assessment (cont.)

<i>Cross Disciplines:</i>	Yes	No
Are therapists involved in the agency fall prevention program for planning, development, implementation and evaluation of the program?	<input type="checkbox"/>	<input type="checkbox"/>
Does the fall prevention program have targeted interventions for home health aides and medical social workers ?	<input type="checkbox"/>	<input type="checkbox"/>
Do nurses evaluate the medication regimen as part of fall prevention?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a process for evaluating the medication regimen for therapy only patients?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Culture:</i>	Yes	No
Does the agency focus on prevention rather than reacting to single fall incidents?	<input type="checkbox"/>	<input type="checkbox"/>
Points for recognizing a culture of fall prevention:		
• Clinicians identify at-risk patients and incorporate preventative interventions in care plan.	<input type="checkbox"/>	<input type="checkbox"/>
• Clinicians approach fall prevention with an interdisciplinary team collaboration.	<input type="checkbox"/>	<input type="checkbox"/>
• Patients are referred for PT and OT evaluations routinely based upon identified fall risk.	<input type="checkbox"/>	<input type="checkbox"/>
• Interventions are individualized but the overall focus of prevention is unchanged.	<input type="checkbox"/>	<input type="checkbox"/>
Points for recognizing a culture of reacting to fall incidents without focusing on prevention:		
• The focus is on patient fall incidents and follow up that occurs after incident.	<input type="checkbox"/>	<input type="checkbox"/>
• Nurses refer to therapy for patients who are at risk for falls—but targeted interventions are not coordinated for fall prevention.	<input type="checkbox"/>	<input type="checkbox"/>
• Fall prevention is not an interdisciplinary team effort.	<input type="checkbox"/>	<input type="checkbox"/>

Tip: Utilize the ICD 9 Code V15.88 history of falls; high risk for falls

Fall Prevention Leadership Action Items



Consistent:

- Develop and implement the consistent use of a **fall risk assessment tool** if agency does not currently have a fall risk assessment (sample on page 23).
- Review and modify existing fall risk assessment tool for appropriateness in evaluating patient fall risk and for linking to patient-centered interventions.
- Incorporate fall risk assessment components with ACH risk assessment.
- Consider incorporating fall risk assessment as part of electronic record for point of care providers.
- Add a home safety assessment to fall prevention program with guidelines; identify if therapist or nurse will perform assessment (“Check for Safety” pamphlet at www.cdc.gov).
- Create a standard patient/caregiver education sheet (sample on page 24 and **Spanish version** on www.homehealthquality.org).
- Monitor (chart audits and/or patient interviews) to evaluate if fall risk assessment and interventions are used consistently and if fall assessment is consistently identifying patients at risk.
- Coach and instruct individuals who do not comply with the fall prevention program.
- Review all patient falls to assess staff adherence with the fall prevention program requirements (see sample Fall Report on page 28).
- Assure that patient risk for falls is addressed not only at SOC/ROC, but anytime patient condition significantly changes.

Coordinated:

- Coordinate the fall risk assessment with fall prevention interventions (e.g., if score of ___, then obtain order for PT, OT...).
- Initiate dialog between clinical, administrative and financial staff to evaluate depth of problem and to improve processes.
- Educate staff regarding the principles, processes and potential interventions of the fall prevention program.
- Assure that processes for implementation of interventions are seamless to promote staff buy-in with program.
- Review and modify policies and procedures to support the fall prevention program.
- Arrange case conferences for patients who are at risk or have fallen and adapt care plans accordingly.
- Track fall prevention outcomes and use the findings to support the fall prevention program.

Leadership Action Items (cont.)

Cross Disciplines:

- Involve **therapy staff** in agency fall prevention program—including planning, development, implementation and evaluation of the program.
- Ask therapist(s) to organize and deliver a staff in-service on fall prevention.
- Review sample Timed Up and Go technique on page 24 and plan to incorporate into agency practices, orientation and competencies for clinicians.
- Target fall prevention interventions **for all staff** (e.g., home health aide—refer for patients who are ‘at risk’ of falling in tub/shower; medical social worker—referrals for patients who need assistance with resources for modifications to home environment).
- Include nurse evaluation of medication regimen, medication reconciliation and a medication evaluation process for therapy only patients.
- Devise system to monitor and evaluate underlying causes for falls.
- Determine orthostatic hypotension protocols and educate all clinical staff (see page 27 for education guide and also page 36 for additional resources).


Culture:

Leadership must endorse the fall prevention program for staff to have buy-in.

- Build a culture of prevention, not reaction!
- Use visual displays to promote the program
- Ask staff for individual and group feedback on the program
- Personalize the fall prevention program

Don't forget to update your Emergency Care Plans related to the agency's Fall Prevention Plan!

MY EMERGENCY PLAN

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <p>Trouble moving or fell</p>	<ul style="list-style-type: none"> Dizziness or trouble with balance Fell and hurt myself Fell but didn't hurt myself 	<ul style="list-style-type: none"> Fell and have severe pain

Leadership Action Plan



Using the Leadership Action Items (pages 19 -20), request that leadership team members select and prioritize **two to four items** that they want to implement or modify. You may choose to add more action items after accomplishing your priority action items.



Date	Action	By Whom	Status
	Review care discipline tracks to determine what portions of this Best Practice Intervention Package – Fall Prevention you choose to use and how you want to utilize them.		
	Review the selected tools in the package and choose the most appropriate tool(s) to initiate or optimize your fall prevention program: <ul style="list-style-type: none"> <input type="checkbox"/> Fall Risk Assessment <input type="checkbox"/> Patient & Caregiver Education Sheet (English and Spanish available) <input type="checkbox"/> Accurately Assessing Orthostatic Hypotension Education Guide <input type="checkbox"/> Timed Up and Go Screening Tool <input type="checkbox"/> Fall Report Form 		

Fall Prevention Implementation Tools: How to Use

Fall Risk Assessment Screening Tool

- Use the sample-screening tool to create or modify agency's fall risk assessment
 - Posted on www.homehealthquality.org

Timed Up and Go

- Review screening tool to assist clinicians in determining high-risk for falling
- Use the video PowerPoint that is available on www.homehealthquality.org for demonstration of performing the screening

Patient & Family Caregiver Education Sheet

- Personalize the “What You Can Do to Prevent Falls” and provide to patients
 - Posted on www.homehealthquality.org

Accurately Assessing Orthostatic Hypotension Education Guide

- Read this resource and begin or modify existing agency protocols related to orthostatic hypotension
- Educational guide is also included in the nursing and therapy tracks

Fall Report Form

- Use or modify sample report form to track and investigate falls

Patient & Family Connection

- Use this connection page in your fall prevention team meeting to assist with keeping a focused patient-centered program

Hospice Connection

- Share key concepts from a hospice/palliative perspective
- Include hospice/palliative staff with planning stages

Physician Connection

- Share tips for improving physician relationships with hospital liaisons, managers and clinical staff
- Sample SBAR for patient scenario for a fall

Managed Care Connection

- Share with agency staff who obtain authorizations

Continuum of Care Connection

- Share at leadership/management meetings for awareness of connection of fall prevention to all health care settings and to other quality improvement organizations' priorities

Poster

- Display poster throughout agency with the other HHQI posters or independently

Examples of Excellence

- Insert one of the stories in your agency newsletter for staff or post in agency

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 a 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 plus seconds	Diminished mobility

The Timed Up and Go score with hospitalization risk assessment findings and **clinical decision-making** will identify patients at risk for falling. 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.

Leadership Considerations:

- Determine a standard Time Up and Go technique (numerous available, this is just one sample)
- Determine how often Timed Up and Go is to be completed
- Include Timed Up and Go in orientation with annual competencies
- Ask therapists to teach the technique and evaluate competency
- Utilize the video PowerPoint available for demonstration (see page 44)

Modified from the APTA’s Balance and Fall Awareness Event Instruction Booklet for Physical Therapists, copyright 1999 American Physical Therapy Association. Used with permission.

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**
- 2. Have your health care provider review your medicines**
- 3. Have your vision checked**
- 4. Make your home safer**

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


About half of all falls happen at home. To make your home safer:

- Remove things you can trip over (like papers, books, clothes and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double-sided tape/rug grippers to keep the rugs from slipping.
- Keep items you use often in cabinets you can reach easily without using a step stool.
- Have grab bars put in next to your toilet and in the tub or shower.
- Use non-slip mats in the bathtub and on shower floors.
- Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang lightweight curtains or shades to reduce glare.
- Have handrails and lights put in on all staircases.
- Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.



5. Other Safety Tips

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Think about wearing an alarm device that will bring help in case you fall and can't get up.
- National Center for Injury Prevention and Control. (2006). www.cdc.gov/ncipc/pub-res/toolkit/WhatYouCanDoToPreventFalls.htm *What To Do If You Fall.*

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 <p>Trouble moving or fell</p>	<ul style="list-style-type: none"> • Dizziness or trouble with balance • Fell and hurt myself • Fell but didn't hurt myself 	<ul style="list-style-type: none"> • Fell and have severe pain

Resource: Centers for Disease Control and Prevention

Accurately Assessing Orthostatic Hypotension



Polish Your Practice

Introduction

Orthostatic hypotension (postural hypotension) can be a **significant and common problem** that often is a contributing factor to the incidence of falls. Technique, timing and positioning **contribute to accurate orthostatic hypotension assessment.**

What is Orthostatic Hypotension?

- Orthostatic hypotension is a physical finding, not a disease and may be symptomatic or asymptomatic. Treatment is generally aimed at the underlying cause.
- Orthostatic hypotension occurs when blood pressure drops in response to position change.
- Orthostatic hypotension is commonly defined as occurring when there is any one or combination of the following vital sign changes:
 - Decrease of 20 mmHg (or more) in systolic blood pressure
 - Decrease of 10 mmHg (or more) in diastolic blood pressure
 - Increase in heart rate of greater than or equal to 20 bpm

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

Home Care Fall Reduction Initiative Fall Report Form

Definition of a fall: An unintentional change in position resulting in coming to rest on the ground or at a lower level		
Patient Name: _____		
Patient Chart # or ID# _____		
Date of fall: _____		
Circle or enter the appropriate response		
1. Did the fall occur during the first 30 days of care?	YES	NO
2. Fall was witnessed by a home care worker?	YES	NO
3. Was risk identified at start of care/ROC (from Falls Risk Assessment)? *	YES	NO
4. Was physical therapy ordered and had it begun at the time of the fall?	YES	NO
5. Was nursing ordered at the time of the fall?	YES	NO
6. Was there an injury requiring emergent care? *	YES	NO
a.) If yes, was the injury a hip fracture?	YES	NO
7. Medications		
a.) Were there any medication changes within two weeks of the fall?	YES	NO
b.) Number of prescription medications the patient is taking		
c.) The number of prescription pain medications the patient is taking		

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*Risk is identified if the patient had 4 or more points from the MAHC Risk Assessment elements

**The OASIS definition of "emergent care" is:

- Hospital emergency room (includes 23-hour holding),
- Doctor's office emergency visit/house call,
- Outpatient department/clinic emergency (includes urgent center sites).



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Patient – Family Connection Fall Prevention

“Houston, we have a (potential) problem”



- Patient/caregiver reveals accurate fall history and identified personal fall risks
- Clinician collaboratively completes an accurate fall risk assessment with patient and caregiver
- Clinician explains risk factors and potential impact to patient
- Patient/caregiver recognize potential harm from falls

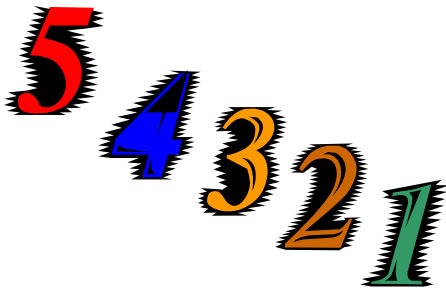
Engineering a Solution



- Clinician selects and discusses the most appropriate fall risk prevention actions
- Patient/caregiver actively participates in the development of a personal fall prevention plan
- Clinician informs physician of identified risk factors and targeted patient-centered fall prevention plan developed by patient/caregiver and clinician

Lift-off!!

- Clinician and patient/caregiver successfully implement the patient-centered fall prevention plan
- Patient/caregiver engage in plan and make necessary behavioral and environmental safety accommodations
- Goal – reduce incidence of falls and avoidable acute care hospitalizations



Physician Connection Fall Prevention



Include physicians as part of the team to prevent falls

Communicate with physicians:

- Patient fall risk factors and suggest interventions
- Fall occurrence
- Change in patient status affecting balance
- Environmental concerns
- Indications of orthostatic hypotension

Share with physicians:

- Agency efforts in fall prevention
 - Emphasize the program is not just identifying risk, but providing patient-centered interventions
 - Patient/caregiver resources for educating about falls

Key indicators of fall risk from a physician perspective...

- Has patient fallen in recent past?
- Does patient have a fear of falling?
-- Joseph G. Ouslander, MD

Example of Physician Communication

Situation: Dr. S, I am _____ calling from XYZ Home Care about Mrs. J who is at high risk for falling.

Background: Mrs. J is an 84-year old female with CHF, diabetes and a history of falls with subsequent fractures. She has full function of all extremities, but is afraid of falling. She was admitted to home care yesterday post hospitalization for CHF.

Assessment: Mrs. J has a potential for falling again, as exhibited by her fear of falling, weakened condition and unstable balance. She utilizes furniture when ambulating and uses a cane intermittently. Her medications have not changed and were evaluated as not likely to be contributing factors.

Recommendation: I would like to have an order for physical therapy to evaluate balance training and strengthening, and occupational therapy to help with ADL/IADL management and environmental modifications. Also, when you see her tomorrow, could you reinforce the need to make some environmental modifications with her? She seems reluctant to remove some of her throw rugs and we would like to help her arrange to have a safety railing installed. Your support would be important to her.

Hospice and Palliative Connection

Fall Prevention

Hospice providers demonstrate the ability to help patients remain in their home and avoid hospitalizations. Patient safety is the number one priority for every nurse. Prevention of falls is one way to assure patient safety especially when caring for the palliative or hospice patient.

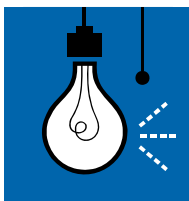
What can home care learn about fall prevention from hospice?

Priority #1: Fall Risk Assessment

- Fatigue may be a fall risk factor, especially for those facing serious illness.
- Make the ‘fall connection’ when reviewing medications. Opioids, anti-anxiolytics and diuretics contribute to falls.
- Consider patterns of elimination when evaluating risk factors of the debilitated patient.

Priority #2: Proactive Fall Prevention Interventions

- Falls will happen. Be prepared to minimize risk.
- Consider the patient goal of care when developing a fall prevention plan. Prevention of falls may not be possible due to the patient-defined goal of care. How can you minimize the dangers of the falls that are bound to happen?
- Involve ALL members of the team in fall prevention including nursing, social work, physical therapy, pharmacist and family.



Suggestion:

Include members of your palliative/hospice team on your fall prevention program team or consult with a local hospice provider.

Managed Care Connection Fall Prevention

Fall Risk Management—a health plan HEDIS measure

The **Healthcare Effectiveness Data and Information Set (HEDIS)** is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans [NCQA].

HEDIS Measure: Fall Risk Management

The Connection:

Leadership:

- Include your agency fall prevention program in **payer contract negotiations**
- Share your agency's adverse event report for 'Emergent Care for Injury Caused by Fall or Accident at Home' and **fall data evaluation** with payers

What you can do...

Clinicians:

- Include a patient's **fall risk** when providing update to case manager
- Follow with planned **interventions** and goals to support requested disciplines and visit frequencies

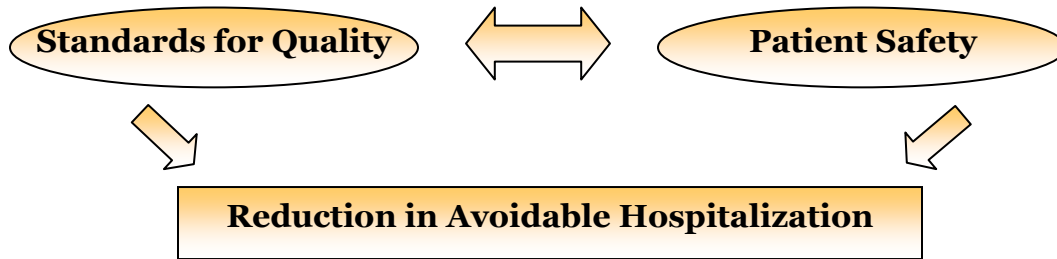
Resource: The National Committee for Quality Assurance, <http://web.ncqa.org/>

Continuum of Care Connection Fall Prevention

Linking Resources: Community, Aging Service Network and Health Care Systems

Continuum of Care Questions

- ☑ Standard definitions are used across all health care settings?
- ☑ Standards are an integral part of day-to-day practice?
- ☑ Competent and consistent staff is using interventions across disciplines?
- ☑ Intervention implementations are seamless during transitions of care?
- ☑ Outcome measurements are defined and monitored?
- ☑ Processes and systems are in place to ensure there is equity for all individuals related to fall prevention assessment, harm reduction and interventions?



Leaders in Establishing Fall Prevention Standards: (Partial Listing)

Who	Resource/Requirement
Joint Commission	http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals Reduce the risk of patient harm resulting from falls 2008 National Patient Safety Goals for Home Care Programs
IHI & RWJ	Reducing Harm From Falls: Closing the Gap Institute for Healthcare Improvement & Robert Wood Johnson Foundation http://www.ihc.org/IHI/Topics/PatientSafety/ReducingHarmfromFalls/Literature/
American Geriatrics Society	Guideline for the Prevention of Falls in Older Persons JAGS (2001); 49: 664-672.
Fall Prevention Center of Excellence	Mission is to identify best practices in fall prevention and to help communities offer fall prevention programs to older people who are at risk of falling. http://www.stopfalls.org/
National Council on Aging (NCOA)	NCOA with support from the Archstone Foundation and the Safety Council is spearheading a national fall prevention action plan.
CDC Injury Center	A toolkit to prevent senior falls http://www.cdc.gov/ncipc/duip/preventadultfalls.htm
Veterans Administration	National Center for Patient Safety – 2004 toolkit http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html

Fall Prevention

It's more than fall risk assessment...



**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.



Fall Prevention Post-Test Answer Keys

Each track of the Best Practice Intervention Package has a post-test that providers may choose to complete after reviewing the track and completing the activities.

For the Fall Prevention package, the post-tests are found on the following pages:

Nurse Track – page 50

Therapist track – page 63

Medical Social Work Track – page 71

Home Health Aide Track – page 78

Use the answer keys below to score the post-tests included with the **Best Practice Intervention Package – Fall Prevention**

Nursing Post-Test Answers:

1. A
2. E
3. C
4. A
5. C

Therapist Post-Test Answers:

1. A
2. E
3. C
4. A
5. C

Medical Social Worker Post-Test Answers:

1. A
2. E
3. C
4. A
5. C

Home Health Aide Post-Test Answers:

1. A
2. D
3. E
4. A
5. E

Resources

<http://www.cdc.gov/ncipc/pub-res/toolkit/toolkit.htm>

CDC fall prevention information, statistics and resources.

<http://www.americangeriatrics.org/products/positionpapers/Falls.pdf>

Guideline for the Prevention of Falls in Older Persons; American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopedic Surgeons Panel on Falls Prevention

<http://www.safeaging.org/model/default.asp>

National Resource Center for Safe Aging; Information for public health professionals related to falls: research based best practices, fall prevention programs, etc.

<http://www.va.gov/ncps/SafetyTopics/fallstoolkit/index.html>

U.S. Dept. of VA Affairs; National Center for Patient Safety; 2004 Falls Toolkit

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

Aging in the Know: Health and Aging Resources; Created by the American Geriatrics Society Foundation for Health in Aging (FHA), *Aging in the Know* offers up-to-date information for consumers on health and aging—including fall prevention.

<http://www.aafp.org/afp/20000401/2159.html>

American Family Physician web site; falls in the elderly: professional information, statistics, resources, article links, and patient information.

<http://www.homecaremissouri.org/index.cfm>

Missouri Alliance for Home Care Web site; Information and resources on the Home Care Fall Reduction Initiative

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