

IN-HOME QUALITY IMPROVEMENT

BEST PRACTICE: FALL PREVENTION

NURSE TRACK



Best Practice Intervention Packages were designed for use by any In-Home Provider Agency to support reducing avoidable hospitalizations and emergency room visits. Any In-Home care nurse/clinician can use these educational materials.

Best Practice Intervention Packages were designed to educate and create awareness of strategies and interventions to reduce avoidable hospitalizations and unnecessary emergency room visits.

Nurse Track

This best practice intervention package is designed to educate and support nurses on the priorities necessary for a comprehensive In-Home fall prevention program that will support reducing avoidable acute care hospitalizations.

Objectives

After completing the activities included in the Nurse 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 In-Home fall prevention program.
2. Describe how fall prevention will support reducing avoidable acute care hospitalizations.
3. Describe two nursing actions that will ensure optimal fall prevention for staff, patients and caregivers.

Complete the following activities:

- Read the Nurses' Guide to Fall Prevention.
- Read the Fall Prevention: Physician Connection.
- Read the Accurately Assessing Orthostatic Hypotension.
- Review the Fall Risk Assessment Tool.

Access the *Timed Up and Go* Video located at: www.homehealthquality.org with the Fall Prevention Best Practice Intervention Package (BPIP), under Video. **You will need to log in and go to My Links, Fall Prevention BPIP. Go to the Video section and click on the Timed Up and Go video. (You cannot access this audio if your agency has not signed on as a member of the Home Health Quality Improvement Campaign. For instructions for signing up on the HHQI website, go to the welcome page of the Missouri In-Home Quality Campaign**
[-http://www.dhss.mo.gov/seniors/hcbs/qualitycampaign.php](http://www.dhss.mo.gov/seniors/hcbs/qualitycampaign.php))

- Review the Timed Up and Go Screening Tool.
- Complete the Nursing Post Test.

Disclaimer: Some of the information contained within this Best Practice Intervention Package may be more directed and intended for an acute care setting, or a higher level of care or skilled level of care setting such as those involved in Medicare. The practices, interventions and information contained are valuable resources to assist you in your knowledge and learning.

Disclaimer: All forms included are optional forms; each can be used as Tools, Templates or Guides for your agency and as you choose. Your individual agency can design or draft these forms to be specific to your own agency's needs and setting.

Nurse's Guide to Fall Prevention

Definitions:

- **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 2004, there were more than **320,000** hospital admissions for hip fractures (NCHS 2009).

CDC-Centers for Disease Control and Prevention

AGS-American Geriatrics Society

NCHS-National Center for Health Statistics

How nurses can promote a successful fall prevention program:

1. Assess patients to identify at-risk patients using a fall risk assessment and clinical observation.
2. Select patient-specific interventions for fall prevention.
3. Pursue appropriate referrals from physician and managed care authorizations.
4. Communicate to interdisciplinary team, the patient's fall risk status and planned interventions.
5. Include fall risk and prevention interventions in case conferences.
6. Participate in agency's fall prevention education.

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 assessment that may be:

1. Paper based
2. Included in the hospitalization risk
3. 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 the nurses can implement appropriate preventative interventions.

Included in this module, there is a sample Home Care Fall Reduction Initiative Risk Assessment. (Page 7).

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?

Some fall risk factors...

- Age (>65 years 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>

Potential Interventions for Fall Prevention:

- Complete 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 or adjust for ambulation
- Consider wheelchair and bed alarms, if applicable
- Encourage adequate footwear
- Seek occupational therapy evaluation and instruction for management of ADL/IADLs
- Referral to In-Home aide assistance with bathing, if unsteady
- Case 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 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 cardiovascular problem and contact physician for further intervention (orthostatic hypotension or cardiac arrhythmias)
- Encourage adequate hydration and nutrition and make appropriate referral

Fall Prevention: Physician Connection

Communicate with physicians:

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



Example of Physician Communication using SBAR Communication Method

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 for 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.

For more information about SBAR read the **Physician Relationship Best Practice Intervention Package** and read the Nurse Track.

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 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 positions 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 BR, HR and patient symptoms.
4. If the patient tolerates positions change with no orthostatic hypotension and the patient is able to stand, assist patient to a *standing* position.
 - **Wait 1-2 minutes**, obtain BR/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 Risk Assessment
Screening Tool

Conduct a fall risk assessment on each patient at start of car and re-certification.	
Patient Name: _____	
(Circle one) initial visit, semi-annual Date: _____	
Required Core Elements Assess one point for each core element “yes”	Points
Age 65+	
Diagnosis (3 or more co-existing) <i>Assess for hypotension</i>	
Prior history of falls within 3 months Fall Definition: <i>“An unintentional change in position resulting in coming to rest on the ground or at lower level.”</i>	
Incontinence Inability to make it to the bathroom or commode in timely manner includes frequency, urgency and/or nocturia.	
Visual impairment Includes macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly pharmacy (4 or more prescriptions) Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual’s desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer’s or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling	Total

Nurse's Signature _____

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 comfortable 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 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 the patient.

Nurse Name: _____

Date: _____

NURSING POST TEST

Fall Prevention

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

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. Falls prevention may reduce avoidable acute care hospitalizations by using each of the interventions below **except**:
 - A. Completion of a fall risk assessment to identify those patients at risk for falling
 - B. Implementation of patient-specific fall prevention interventions prior to a fall occurring
 - C. Fitting everyone with a standard walker
 - D. Requesting referrals to appropriate therapies to assist patients with strength, gait and balance improvement early in the episode of care

4. Nurses cannot manage fall prevention independently. Nurses 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.