Home Health Quality Improvement National Campaign

Best Practice Intervention Package - Fall Prevention
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Best Practice: Fall Prevention

Leadership Track

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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:

<table>
<thead>
<tr>
<th>Role</th>
<th>Review Fall Risk Assessment</th>
<th>Review Fall Prevention Guide</th>
<th>Review Assessing Orthostatic Hypotension</th>
<th>Listen to Podcast</th>
<th>Complete Timed Up &amp; Go Activity</th>
<th>Read Examples of Excellence</th>
<th>Complete scenario exercises</th>
<th>Complete Post Test for certificate</th>
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- 6 -
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.

**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].
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.


“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/agingintheknow](http://www.healthinaging.org/agingintheknow)

“*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


Christian 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

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 anti-cholinergic 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](http://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.
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

- 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

#### Consistent:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Does agency have a fall risk assessment?</td>
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<tr>
<td>Is the fall risk assessment addressed <strong>at SOC, ROC</strong> and with <strong>changes</strong> in patient status?</td>
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<tr>
<td>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?’)</td>
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<td>Does the fall risk assessment include <strong>targeted interventions</strong>?</td>
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<td>Does staff understand the necessity of completing a fall risk assessment and following through with targeted interventions?</td>
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<tr>
<td>Is monitoring (chart audits or patient interviews) completed to evaluate if fall risk assessment and interventions are used consistently?</td>
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<td>Do managers meet with individuals who do not comply with the fall prevention program - either with risk-identification assessments or with implementing interventions?</td>
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<tr>
<td>Are patient falls evaluated to see if the patient was identified as at risk and if interventions were appropriately implemented?</td>
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#### Coordinated:

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<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Are <strong>case conferences</strong> held for patients who:</td>
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<tr>
<td>- Are <strong>at risk</strong> for falls?</td>
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<tr>
<td>- <strong>Have fallen</strong>?</td>
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<td>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)</td>
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<td>Do you offer annual mandatory fall prevention in-services to clinicians?</td>
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<tr>
<td>Are monitoring results shared with all staff? (Showing consistency of fall risk assessment and interventions)</td>
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<td>Are adverse events shared with all staff?</td>
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<td>Are patient falls tracked for trending and evaluation of causes?</td>
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<td>Are underlying causes for falls considered? (e.g., syncope could be cardiovascular related)</td>
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**Agency Assessment (cont.)**

### Cross Disciplines:

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<td>Are therapists involved in the agency fall prevention program for planning, development, implementation and evaluation of the program?</td>
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<tr>
<td>Does the fall prevention program have targeted interventions for home health aides and medical social workers?</td>
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<tr>
<td>Do nurses evaluate the medication regimen as part of fall prevention?</td>
<td>☐</td>
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<tr>
<td>Is there a process for evaluating the medication regimen for therapy only patients?</td>
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### Culture:

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<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Does the agency focus on prevention rather than reacting to single fall incidents?</td>
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**Points for recognizing a culture of fall prevention:**
- Clinicians identify at-risk patients and incorporate preventative interventions in care plan.
- Clinicians approach fall prevention with an interdisciplinary team collaboration.
- Patients are referred for PT and OT evaluations routinely based upon identified fall risk.
- Interventions are individualized but the overall focus of prevention is unchanged.

**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.
- Nurses refer to therapy for patients who are at risk for falls—but targeted interventions are not coordinated for fall prevention.
- Fall prevention is not an interdisciplinary team effort.

---

**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](http://www.cdc.gov)).
- Create a standard patient/caregiver education sheet (sample on page 24 and Spanish version on [www.homehealthquality.org](http://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

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble moving or fell</td>
<td>• Dizziness or trouble with balance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fell and hurt myself</td>
<td>• Fell and have severe pain</td>
</tr>
<tr>
<td></td>
<td>• Fell but didn’t hurt myself</td>
<td></td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>By Whom</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review care discipline tracks to determine what portions of this <strong>Best Practice Intervention Package – Fall Prevention</strong> you choose to use and how you want to utilize them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review the selected tools in the package and choose the most appropriate tool(s) to initiate or optimize your fall prevention program:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Fall Risk Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Patient &amp; Caregiver Education Sheet (English and Spanish available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Accurately Assessing Orthostatic Hypotension Education Guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Timed Up and Go Screening Tool</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Fall Report Form</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
Conduct a fall risk assessment on each patient at start of care and re-certification.

**Patient Name:** ____________________________________________

(Circle one) SOC, ROC or Re-certification  
**Date:** ____________________

### Required Core Elements
Assess one point for each core element “yes”

<table>
<thead>
<tr>
<th>Points</th>
</tr>
</thead>
</table>

| **Age 65+** |
| **Diagnosis (3 or more co-existing)**  
*Assess for hypotension* |
| **Prior history of falls within 3 months**  
*Fall Definition, “An unintentional change in position resulting in coming to rest on the ground or at a lower level.”* |
| **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 retinopaties, 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, and 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**

**Clinician’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 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

<table>
<thead>
<tr>
<th>TIME</th>
<th>SCORE</th>
</tr>
</thead>
</table>

**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
   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.

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| 🙁 Troubles moving or fell | • Dizziness or trouble with balance  
• Fell and hurt myself  
• Fell but didn’t hurt myself | • Fell and have severe pain |

Resource: *Centers for Disease Control and Prevention*

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-HHQ07.637. App. 9/07.
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:**

<table>
<thead>
<tr>
<th>Circle or enter the appropriate response</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the fall occur during the first 30 days of care?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2. Fall was witnessed by a home care worker?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3. Was risk identified at start of care/ROC (from Falls Risk Assessment)? *</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4. Was physical therapy ordered and had it begun at the time of the fall?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5. Was nursing ordered at the time of the fall?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6. Was there an injury requiring emergent care? *</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>a.) If yes, was the injury a hip fracture?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>7. Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.) Were there any medication changes within two weeks of the fall?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>b.) Number of prescription medications the patient is taking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.) The number of prescription pain medications the patient is taking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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).
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. Opiods, 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

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

What you can do...

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?

Standards for Quality  Patient Safety

Reduction in Avoidable Hospitalization

Leaders in Establishing Fall Prevention Standards: (Partial Listing)

<table>
<thead>
<tr>
<th>Who</th>
<th>Resource/Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Prevention Center of Excellence</td>
<td>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. <a href="http://www.stopfalls.org/">http://www.stopfalls.org/</a></td>
</tr>
<tr>
<td>National Council on Aging (NCOA)</td>
<td>NCOA with support from the Archstone Foundation and the Safety Council is spearheading a national fall prevention action plan.</td>
</tr>
<tr>
<td>CDC Injury Center</td>
<td>A toolkit to prevent senior falls <a href="http://www.cdc.gov/ncipc/duiip/preventadultfalls.htm">http://www.cdc.gov/ncipc/duiip/preventadultfalls.htm</a></td>
</tr>
</tbody>
</table>
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

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

Orthostatic Hypotension References


Best Practice:
Fall Prevention

Nurse 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.
This best practice intervention package is designed to educate and support nurses on 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 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 home health 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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the Nurses’ Guide to Fall Prevention and Accurately Assessing Orthostatic Hypotension. Review the Fall Risk Assessment tool</td>
<td>Page 39</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Listen to podcast</td>
<td>Page 44</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
| Watch the Timed Up and Go video PowerPoint                                | Page 44    | 25 minutes     | OR
| Read the Timed Up and Go instructions and practice performing it with a co-worker | Page 45    | 25 minutes     | OR
| Read Examples of Excellence                                              | Page 46    | 10 minutes     |
| RNs: Complete the nursing evaluation and post-test online for free CNEs  | See link below | 10 minutes    |
| LPNs: Complete the nursing post-test online for free certificate of participation | See link below | 10 minutes    |

**Total time for completion** 80 minutes

**RNs:** Apply for free 1.3 Continuing Nursing Education units for completing the nursing track activities. **Complete evaluation/post-test online at:**

**LPNs/LVNs:** Apply for a certificate of attendance for completing the nursing track activities. **Complete evaluation/post-test online at:**
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 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 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. Collaborate with therapists on OASIS accuracy to capture fall risk
3. Select patient-specific interventions for fall prevention
4. Pursue appropriate referrals from physician and managed care authorizations
5. Communicate to interdisciplinary team patient’s fall risk status and planned interventions
6. Include fall risk and prevention interventions in case conferences
7. 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 risk assessment that may be:
1. Paper based
2. OASIS-based
3. Included in the 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 43 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 45)

**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 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 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/agingintheclimate](http://www.healthinaging.org/agingintheclimate)
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 go to [www.homehealthquality.org](http://www.homehealthquality.org), select 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 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
Conduct a fall risk assessment on each patient at start of care and re-certification.

Patient Name:__________________________________________

(Circle one) SOC, ROC or Re-certification Date: ________________

<table>
<thead>
<tr>
<th>Required Core Elements</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess one point for each core element “yes”</td>
<td></td>
</tr>
<tr>
<td><strong>Age 65+</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnosis (3 or more co-existing)</strong></td>
<td></td>
</tr>
<tr>
<td>Assess for hypotension</td>
<td></td>
</tr>
<tr>
<td><strong>Prior history of falls within 3 months</strong></td>
<td></td>
</tr>
<tr>
<td>Fall Definition, “An unintentional change in position resulting in coming to rest on the ground or at a lower level.”</td>
<td></td>
</tr>
<tr>
<td><strong>Incontinence</strong></td>
<td></td>
</tr>
<tr>
<td>Inability to make it to the bathroom or commode in timely manner</td>
<td></td>
</tr>
<tr>
<td>Includes frequency, urgency, and/or nocturia.</td>
<td></td>
</tr>
<tr>
<td><strong>Visual impairment</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Impaired functional mobility</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental hazards</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Poly Pharmacy (4 or more prescriptions)</strong></td>
<td></td>
</tr>
<tr>
<td>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, and hypoglycemic drugs.</td>
<td></td>
</tr>
<tr>
<td><strong>Pain affecting level of function</strong></td>
<td></td>
</tr>
<tr>
<td>Pain often affects an individual’s desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.</td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive impairment</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

A score of 4 or more is considered at risk for falling Total

Clinician’s signature____________________________________
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 Szcerba, 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 recording) link is located at: 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 Timed Up and Go PowerPoint includes video with Mary Calys, PT, MS, BSW, a 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).

The video PowerPoint link is located at 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
  o Click on Slide Show, View Slide Show
  o 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 _________________

<table>
<thead>
<tr>
<th>Score on a scale of 1 – 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Less than 10 seconds</td>
</tr>
<tr>
<td>2. 10-19 seconds</td>
</tr>
<tr>
<td>3. 20-29 seconds</td>
</tr>
<tr>
<td>4. 30+ seconds</td>
</tr>
</tbody>
</table>

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 patient (see page 40 for examples)

**Video PowerPoint available for demonstration of Timed Up and Go (see page 44)**

St. Agnes Homecare and Hospice is a hospital-based agency in heavily populated metropolitan Baltimore. The agency, which averages about 145 home care episodes per month, assessed its fall records and discovered that falls weren't being reported in the incident reports.

Kathy Chrystal, Performance Improvement Coordinator for St. Agnes, reviewed the agency’s Outcomes Based Quality Improvement (OBQI) reports for patients who had fallen. After reviewing the data, a plan was developed for assessing risk for falls and interventions to lower the incidence of falls, which can often lead to acute care hospitalizations. Chrystal says the agency was prompted to look at the incidence of falls after reviewing the Joint Commission fall risk prevention guidelines.

**Finding the Hidden Causes**
The agency assembled an interdisciplinary team to audit charts and identify key factors contributing to an increased risk for falls, including:
- Patients who live alone or with an elderly caregiver
- Physical weakness and trouble standing
- Impaired vision or hearing
- Confusion
- Polypharmacy and medications that may increase fall risk
- Home environment – insufficient handrails, presence of stairs
- Inappropriate footwear
- Obtrusive medical devices such as oxygen tanks
- Disease process

“There are so many hidden causes for falls,” says Chrystal, “such as elderly women wearing very dainty, high heeled shoes or patients becoming light-headed with taking medications, such as diuretics. We conducted an in-service that focused on medications that increase the risk for falls such as diuretics and antidepressants.”
Involve Technology
With the green light from the agency director, the St. Agnes team, led by Chrystal, involved clinicians from the start and earned wide support for the development of a fall prevention program. From the supervisors to the medical director to clinicians, all were on board. “We didn’t want to saddle clinicians with another paper form, so we involved our IS [information systems] nurse early,” Chrystal says. Creating an electronic assessment form for a staff that uses laptop computers during visits 80 percent of the time was a win-win, according to Chrystal.

Once the electronic risk assessment was created, the agency tested it with one clinician in each discipline and then educated the entire staff on fall risk assessment and prevention. Home caregivers were then educated by the clinical staff. Chrystal says education was provided to clinicians at monthly meetings.

The rate of completion of the risk assessment form is 100 percent at the start and resumption of care. St. Agnes completes an audit to make sure an assessment is done after a fall. In 2005, the agency reports there were 46 falls that were discovered through patient incident reports or adverse event reports, and 31 fall risk profiles were completed, so the rate of completion was 67 percent. In 2006 there were 23 falls and 17 risk profiles completed after the fall, making a 74 percent completion rate.

Ongoing Process
“It’s been a two-and-a-half year process,” Chrystal says. “First we had to educate the staff about falls, then we had to teach how to use the risk assessment tool, and finally we provided intervention instruction. When we began, we had no intervention education tools, so we researched all types of fall prevention tools, developed one tool and included it in the home chart.”

St. Agnes is randomly auditing to see if the interventions are being used correctly and are working. Some of the interventions the agency has implemented include:
- Teaching safe exercise programs
- Teaching ambulation techniques
- Teaching safe transferring techniques
- Teaching safe use of assistive devices
- Re-evaluating stair climbing ability
- Ensuring adequate pain management
- Completing a home safety evaluation for environmental hazards

Families tell Chrystal that they like the instruction sheets in the home charts, and that they are using them. Chrystal concludes that the agency’s adverse events incidents have dropped dramatically, and that the program is bringing about results – fewer falls, fewer hospitalizations. Between January 2005 and July 2005, the incidence of emergent care for injury caused by fall was 1.01 percent. The following year, between January 2006 and December 2006, emergent care for injury caused by a fall dropped to 0.38 percent.

Information for this article was provided by Kathy Chrystal, St. Agnes Homecare and Hospice.
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.
Nursing Post-Test  
Fall Prevention

RNs – May apply for 1.3 FREE CNEs and LPN/LVN may apply for certificate of participation by following directions on page 38.

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

NURSING

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 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

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the Therapists Guide to Fall Prevention and Accurately Assessing Orthostatic Hypotension. Review the Fall Risk Assessment tool</td>
<td>Page 53</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Listen to podcast</td>
<td>Page 57</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Watch the Timed Up and Go video PowerPoint</td>
<td>Page 57</td>
<td>25 minutes</td>
</tr>
<tr>
<td>OR</td>
<td>Read the Timed Up and Go instructions and practice performing it with a co-worker</td>
<td>Page 58</td>
</tr>
<tr>
<td>Read Examples of Excellence</td>
<td>Page 59</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Complete the therapy post-test online for free certificate of participation</td>
<td>See link below</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

Total time for completion: 80 minutes

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].

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](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
Conduct a fall risk assessment on each patient at start of care and re-certification.

Patient Name: ____________________________________________

(Circle one) SOC, ROC or Re-certification Date: ____________________

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**A score of 4 or more is considered at risk for falling**

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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 Szerba, PT, MPT, Therapy Consultant will share key points on how to successfully implement a fall prevention program.

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*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 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 ________________

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<td>High mobility</td>
</tr>
<tr>
<td>2. 10-19 seconds</td>
<td>Typical mobility</td>
</tr>
<tr>
<td>3. 20-29 seconds</td>
<td>Slower mobility</td>
</tr>
<tr>
<td>4. 30+ seconds</td>
<td>Diminished mobility</td>
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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)**

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*
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.
Therapist Post-Test
Fall Prevention

All therapists, including OTAs and PTAs can apply for a certificate of attendance to use towards continuing education for 1.3 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.
Best Practice: Fall Prevention

Medical Social Worker 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.
Medical Social Worker Track

This best practice intervention package is designed to educate and support social workers 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 Social Worker 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 social worker actions that will ensure optimal fall prevention for staff, patients and caregivers.

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the Medical Social Worker Guide to Fall Prevention and review the Fall Risk Assessment tool</td>
<td>Page 67</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Listen to podcast</td>
<td>Page 70</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Complete the social worker post-test</td>
<td>Page 71</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total Time</strong></td>
<td></td>
<td><strong>35 minutes</strong></td>
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Medical Social Worker’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 that **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 medical social workers can support a successful fall prevention program:**

1. Observe patient for potential risk factors for falls
2. Notify clinicians and managers of identified risk factors
3. Participate in interdisciplinary case conferences for at-risk patients for
   falls
4. Collaborate with clinicians and family to resolve environmental safety
   hazards
5. Be a resource for all staff on fall prevention interventions (e.g. payment
   coverage for adaptive or safety equipment)
6. Provide social support with issues related to caregiver, medication,
   glasses/hearing aid funding, transportation, finances, etc.
7. Assist with developing or refining the agency fall prevention program to
   include social/financial issues

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 it 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 69 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?

Potential Interventions for Fall Prevention:
- Complete home safety evaluation and reduce hazards in the home including:
  - Inadequate lighting
  - Throw rugs, loose flooring
  - Clutter
  - Pets
  - Extension cords
  - Oxygen tubing
- Assist with obtaining necessary adaptive equipment/ramps
- Medication management
- Request physical therapy evaluation and treatment for balance training, strengthening and gait training
- Determine need for assistive device for ambulation
- 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
- Utilize community based organizations as a valuable resource
- Encourage patient to participate in a home 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 nutrition and hydration, request nutrition evaluation referral if needed

Some fall risk factors...
- Age (> 65 years old)
- Mental deficiencies (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/aginginthe know
Home Care Fall Reduction Initiative  
Risk Assessment  
Screening Tool

Conduct a fall risk assessment on each patient at start of care and re-certification.

Patient Name: ___________________________________________________________________

(Circle one) SOC, ROC or Re-certification  Date: ____________________

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Assess one point for each core element “yes”

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Medical Social Worker

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. Fall prevention may reduce avoidable acute care hospitalizations by using any of the following interventions below except:
   A. Completion of a fall risk assessment to identify those patients at-risk for falling
   B. Implementing patient-specific fall prevention interventions prior to a fall occurrence
   C. Fitting everyone with a standard walker
   D. Requesting medical social worker referrals for social support

4. Fall prevention management is interdisciplinary. Medical social workers should be aware of community fall prevention resources and programs. They must work collaboratively with agency interdisciplinary team members and with the patients/caregivers to be successful with fall prevention.
   A. True
   B. False

5. Each of the following is a potential fall prevention interventions that an agency can utilize with patients and caregivers except:
   A. Performing fall risk assessments on all patients
   B. Obtaining appropriate interdisciplinary referrals
   C. Encouraging age-specific immunizations
   D. Encouraging patients to participate in an appropriate exercise program
   E. Providing written fall prevention instruction sheets to patients and caregivers

*Answers to Post-Test are located in the Leadership Section, page 35.*
Best Practice: Fall Prevention

Home Health Aide 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.
Home Health Aide Track

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

Objectives

After completing the activities included in the Home Health Aide Track of this Best Practice Intervention Package — Fall Prevention, the learner will be able to:

1. Describe a fall prevention program.
2. Describe how fall prevention will support reducing avoidable acute care hospitalizations.
3. Describe two home health aide actions that will ensure optimal fall prevention for staff, patients, and caregivers.

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Read the Home Health Aide Guide to Fall Prevention</td>
<td>Page 75</td>
<td>10 minutes</td>
</tr>
<tr>
<td>☐ Review the fall prevention patient scenarios and answer the questions</td>
<td>Page 76</td>
<td>20 minutes</td>
</tr>
<tr>
<td>☐ Listen to podcast (audio recording) and use the discussion questions for group interaction</td>
<td>Page 77</td>
<td>20 minutes</td>
</tr>
<tr>
<td>☐ Complete the home health aide post-test and give to your clinical manager</td>
<td>Page 78</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total Time</strong></td>
<td></td>
<td><strong>60 minutes</strong></td>
</tr>
</tbody>
</table>
Home Health Aide 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** – Identify patients at risk of falling and planning interventions to assist prevention of falling in an effort to reduce hospitalizations.

Importance:
- **More than one third** of adults 65 and older fall each year in the United States [CDC].
- 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].

**How home health aides can support a successful fall prevention program:**
1. Observe for and notify manager of possible risk factors for falls
2. Report witnessed, un-witnessed, and near-falls to clinicians and managers
3. Report home safety hazards such as poor lighting and throw rugs
4. Encourage patient and caregiver to use walkers or canes, if patient has a device
5. Use and encourage family to use gait belts when patient’s gait (walking) is unsteady (Gait belts provides a secure and safe hand hold for caregivers and staff when transferring or walking patients)
6. Ensure proper use of adaptive equipment in bathrooms
7. Remind patients to wear glasses and hearing aids
8. Remind patients to exercise regularly, as ordered
9. Attend agency fall prevention education sessions

**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/aginginthe know](http://www.healthinaging.org/aginginthe know)

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 it also promotes a **proactive approach to fall prevention** rather than reacting to individual falls.
Home Health Aide Scenarios for Fall Prevention

Mrs. S lives alone and has been on home health services for one week. You are visiting twice a week to assist her with her bath. The other disciplines in the home are skilled nursing (SN) and physical therapy (PT). You know SN and PT have spoken with the patient about installing grab bars in the bathroom. Mrs. S does not use her walker all the time during your visit. Mrs. S’s walking is unsteady, and she grabs hold of the toilet and sink in the bathroom to steady herself.

Use the examples from “How Home Health Aides can Support a Successful Fall Prevention Program” on the previous page and/or consider other approaches to list ways the home health aide can promote fall prevention with Mrs. S.

1.

2.

3.

4.

5.

Mr. M was just admitted to home care following a total knee replacement. He is using a walker and following an exercise program as instructed by PT. Mr. M is primary caregiver for his wife who has dementia (memory loss, confusion...). Home health aides are ordered to help Mr. M shower twice a week until he regains strength and has improved balance. PT and HHA are the only services in the home. Mr. M tells you when you are assisting him with his bath that when he awakened during the night he had trouble finding his walker. Apparently his wife had moved it. He asked you not to say anything because it might get both of them in trouble.

Use the examples from “How Home Health Aides can Support a Successful Fall Prevention Program” on the previous page and/or consider other approaches to list ways the home health aide can promote fall prevention with Mr. M.

1.

2.

3.

4.

5.
Fall Prevention Multi-Media Activities
Podcast*(Audio Recordings)

Fall Prevention Podcast (Audio Recording) Instructions:
Listen to the podcast (audio recording) to learn more about reducing avoidable acute care hospitalizations with fall prevention.

Fall Prevention Audio Recording
• 10 minute podcast (audio recording) related to fall prevention
• Podcast (audio recordings) link is located at 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

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Discussion Questions
You may complete these discussion questions together in a group setting (monthly team meeting) or just think about them if you are doing this as a self-study.

• Discuss the importance of fall prevention
• Discuss the impact and importance of the HHA’s role in preventing patient falls
• Can you identify other risk factors we should discuss?
• Is each patient’s risk score and risk factors on your Care Plan? If not, do you know the patient’s score and risk factors? If not, ask agency managers to add the patient fall risk factors to your Care Plan so that you can also be informed of the patient’s risks for falling and be an important contributor to improved patient outcomes. Share your patient risk concerns with your clinicians so that patient falls can be prevented.
Home Health Aide
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 identifying patients who are at risk of falling. Patient-specific interventions are used to assist with decreasing the risk of falling and preventing injury.
   A. True
   B. False

2. Falls can affect the following:
   A. The rate of acute care hospitalization occurrences
   B. Patient injury rate and severity
   C. Patients' fear of falling
   D. All of the above

3. Some risk factors for falls include the following except:
   A. Age
   B. Confusion
   C. Walking problems
   D. Past history of falls
   E. Not having flu shot
   F. Balance problems

4. Home health aides have a very important role with fall prevention. Home health aides can observe patients closely for fall risk factors and report any falls or near falls the patient or caregiver may have mentioned during the visit.
   A. True
   B. False

5. Home health aides can encourage the patient and families to do all of the following to help prevent falls:
   A. Report falls or near falls
   B. Use walkers or canes at all times (if prescribed)
   C. Remind patients to follow their exercise program as ordered by nurse, therapist or physician
   D. Read patient and family fall prevention education material, if provided by the agency
   E. All of the above

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