Fall Prevention

Author: Early M.Borja BSN, MSNc RN, C

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Course Objectives

At the end of the session, the participant will be able to:

1. Recall important statistics pertaining to falls in healthcare settings.
2. Define a “Fall”.
3. Identify possible causes of falls in a healthcare setting.
4. Name the key drivers for a fall prevention program.
5. Name the components of a fall prevention program.
6. Identify fall risk categories in the tool.
7. Assess patients utilizing the Schmid Fall Risk Tool to identify a patient’s safety risks.
8. Discuss steps to take if a fall occurs.
9. Identify elements of documentation.

Introduction

Falls are a serious problem in healthcare organizations. They account for a significant proportion of injuries to hospitalized, ambulatory, long term care, home care and behavioral units patients.

Introduction

- One in three adults 65 and older fall each year
- Fatal falls rank high (#5) per The Joint Commission (TJC) Sentinel Events List.
- Approximately 20-30% of falls result in moderate to severe injuries, which leads to:
  - *> reduced mobility and independence*
  - *> increased risk of premature deaths*
  - *> increased length of hospital stay*
  - *> increased cost of hospital stay*
- *The average hospitalization cost for a fall injury is $19,440.(www.cdc.gov/ncipc/factsheets/fallcost.htm)*

Fall Definition

- Fall:

  " Sudden unexplained change in position in which the patient comes to rest unintentionally on the floor, whether assisted or unassisted."

  SHC Policy& Procedure #30000.01 (11/2006)

- Fall: (Fall rate)

  "The rate per 1000 patient days at which patients experience an unplanned descent to the floor." *California Nursing Outcomes Coalition*

  (Number of falls/Patient days x 1000)

National Fall Data

Range of **Fall rate** per patient for every 1000 bed days:

> Acute Care Hospitals	2.2-7.0
> Long Term Care Hospitals	11.0-24.9
> Rehabilitation Hospitals	8.0-19.8

Test Question

- True or False

Fatal falls ranks high among Joint Commission's list of sentinel events.

Answer

- True

Fatal falls rank number 5 in the Sentinel Events list of The Joint Commission.

Test Question

- True or False

While ambulating a patient, he complains of being dizzy and you assist him gently to the floor.

This is not considered a fall.

Answer

- False

  Any sudden unexplained change in position in which the patient comes to rest unintentionally on the floor, whether assisted or unassisted, is a fall.

Importance of a Fall Prevention Program

- *Institute of Medicine (IOM) To Err is Human*

  Errors are defined as a failure of a planned action to be completed or the use of a wrong plan. Falls are among the problems that occur during the course of health care.

Importance of a Fall Prevention Program

- *The Joint Commission National Patient Safety Goal*
- Reduce the risk of patient harm resulting from falls.

  - Implement a fall reduction program including an evaluation of the effectiveness of the program.

Importance of a Fall Prevention Program

- *Center for Medicare and Medicaid Services (CMS)*

  Beginning October 1, 2008, CMS will no longer pay hospitals additional payment for selected conditions acquired during hospitalizations. Falls are one of those conditions.

Components of a Fall Prevention Program

- Assessment of Fall Risk
- Development of a plan of care
- Evidence-based, multifactoral fall prevention interventions
- Evaluation of fall prevention effectiveness
- Post fall evaluation

Assessment of Fall Risk

- There are several known risk factors for falling. Generally risk factors can be found in the patient and/or in the environment.

Patient:

> Cognitive function
> Mobility
> Continence
> Medications
> Co-morbidities

Environment:

> Room
> Floor surface
> Lighting
> Footwear

Fall Risk Assessment Tool

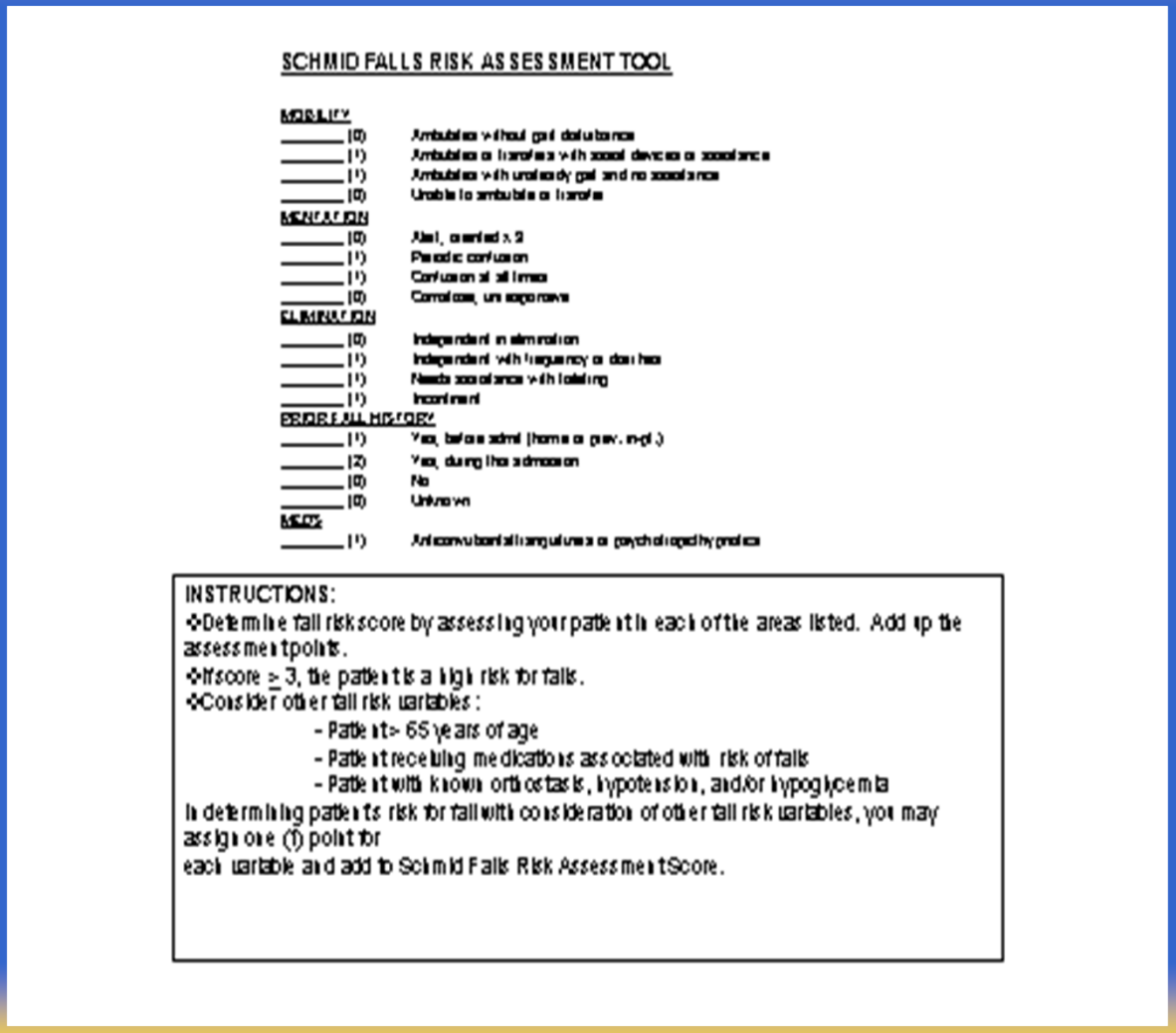
- The Schmid tool quantifies the degree of risk for falls based on five areas associated with risk:
  - >Mobility
  - >Mentation/cognition
  - >Elimination
  - >Prior history of falls
  - >Medications

Identification of Fall Risk

- Using the Schmid Fall Risk Assessment Tool
  - > Assess patient in each category and assign a score
  - > Add up all category scores to obtain total score
- Schmid Score
  - > Score 0-2 = Low risk
  - > Score ≥ 3 = High risk
- Patient is identified at risk for falling in the healthcare setting when:
  - > Schmid score ≥ 3
  - > Prior fall history (prior fall predicts future falls)

Identification of Fall Risk

- Assess fall risk upon admission and transfer to another level of care
- Re-assess whenever there is a significant change in a patient's status or after a fall incident
- Daily or every shift to determine risk



SCHMID FALLS RISK ASSESSMENT TOOL

MOBILITY
_____ (0) Ambulates without gait disturbance
_____ (1) Ambulates or transfers with assist device or assistance
_____ (1) Ambulates with unsteady gait and no assistance
_____ (0) Unable to ambulate or transfer

MENTATION
_____ (0) Alert, oriented x 3
_____ (1) Periodic confusion
_____ (1) Confusion at all times
_____ (0) Comatose, unresponsive

ELIMINATION
_____ (0) Independent in elimination
_____ (1) Independent with frequency or diarrhea
_____ (1) Needs assistance with toileting
_____ (1) Incontinent

PRIOR FALL HISTORY
_____ (1) Yes, before admit (home or prev. m-pl.)
_____ (2) Yes, during this admission
_____ (0) No
_____ (0) Unknown

MEDS
_____ (1) Anticonvulsants/tranquilizers or psycholeptic/hypnotics

INSTRUCTIONS:
- Determine fall risk score by assessing your patient in each of the areas listed. Add up the assessment points.
- If score ≥ 3, the patient is a high risk for falls.
- Consider other fall risk variables:
  - Patient > 65 years of age
  - Patient receiving medications associated with risk of falls
  - Patient with known orthostasis, hypotension, and/or hypoglycemia

In determining patient's risk for fall with consideration of other fall risk variables, you may assign one (1) point for each variable and add to Schmid Falls Risk Assessment Score.

Test question

- True or False

The Schmid Fall Risk Assessment Tool is used in all clinical areas to identify patient's risk for falling while hospitalized.

Answer

- True

  Schmid Fall Risk Assessment Tool is completed upon admission and patient's transfer to another level of care and after a fall incident.

Question

- True or False

  Schmid score of ≥ 3 or more and prior history of falls identifies patient at risk for falling in the hospital.

Answer

- True
  - Patient Schmid score of ≥ 3 or more and prior history of falls identifies him/her at risk for falling.

Fall Risk Assessment

- Based on the patient and environmental factors that can contribute to falls, other factors to consider in addition to the Schmid include:
  - > Age: more than 1/3 of adults 65 years and older fall each year
  - > Mobility: older at risk patients should have a brief assessment of their gait & balanc >
  - > Vision: vision problems can contribute to falls and should be assessed (IA, 2004)

Fall Risk Assessment

- Medications:
  - CNS/psychotropics – sedatives/hypnotics, tricyclic antidepressants, selective serotonin- reuptake inhibitors, antipsychotics/neuroleptics, benzodiazepines
  - Cardiovascular drugs – diuretics, antiarrhythmics, cardiac glycosides
  - Number of meds – the more meds of any type, the higher the risk

Fall Risk Assessment

- Underlying conditions:
  - Postural hypotension
  - Dementia – cognitive status screening
  - Neuro problems
  - Cardiovascular problems
  - Psychological factors – fear of falling

  Environment: older adults report tripping and slipping as common reasons for falling

Test Question

True or False

4 or more medications increases a patient's risk for falls.

Answer

- True

As the number of medications increases so does the risk for falls.

Medication use like diuretics can increase patient's risk for falls.

Question

- True or False

Other underlying conditions that may increase patient's risk are impaired cognition and neurological problems.

Answer

- True

  Impaired cognition and neurological problems increases patient's risk for falling.

Development of a Plan of Care

- The patient's plan of care includes targeted interventions individualized to the patient's risk factors.
- When developing a plan of care to prevent falls, it is important to discuss with the patient/family any factors that may be placing him/her at risk for falling and to identify interventions specific to those risks.

Development of a Plan of Care

Communication of Fall Risk

- Communicate patient's risk for falling at each and every patient handoff!!
- Different facilities have different methods of communicating a patient's fall risk. Some methods include:
  - Symbols (maple leaf, falling star) on patient's door
  - Stickers placed on patient's chart
  - Magnets on assignment board

Question

- True or False

The IPOC must include interventions individualized to the patient's risk factors.

Answer

- True

The IPOC must include interventions individualized to the patient's risk factors.

Preventive Interventions

- Standard Interventions for all patients (Schmid score 0 – 2, Low Risk)
  - Bed in low position, brakes locked
  - Side rails up (2x), call bell within reach
  - Personal items within reach
  - Unobstructed, clear path to bathroom
  - Adequate lighting
  - Floor clean and dry

- Environmental modification is a component of fall prevention strategies.

Preventive Interventions

Interventions for high risk patients (Schmid Score ≥ 3, prior fall history)

- Treat identified underlying condition (s)
- Modify risk factors
  - Strength, balance, gait (PT consult)
  - Medications (reduce, eliminate, substitute)
  - Bladder/bowel function (toileting program)
- Monitor
  - Move patient closer to nurses station
  - Hourly rounding
- Manage factors (anticoagulation, osteoporosis, malnutrition) that may cause serious injury (bleeding, fracture, trauma) if fall occurs

Preventive Interventions

- Patient/Family Education
- Unit specific tips: (brochures may be available)

- Emphasis on:
  - Room and bathroom safety tips
  - Available family resources for safety concerns.
  - Safety devices available for confused patients
  - Possible injuries from falls and how to prevent them

Preventive Interventions

A note on *restraint* use …

- There is no evidence that supports the use of restraints as a fall prevention strategy.
- Restraints may increase the risk of falling. The potential for harm outweighs the benefits.
- Older adults who are restrained are more likely to fall than those who are not restrained.

Test question

- True or False

One of the standard interventions for a patient identified as a high risk for falls is to use restraints.

Answer

False

Restraints may increase the risk of falling or the potential for harm outweighs the benefits.

Use of restraints is not a guarantee that patient will not fall while hospitalized.
For Restraint Utilization & Management Process,
please refer to SHC P&P.

Evaluation of Interventions

- Continue to reassess patient's risk and evaluate potential strategies (referral, equipment, sitter, etc.)
- Revise/update the plan of care

Injury Prevention

- Consider the use of the following injury prevention equipment:
  - Low Bed
  - Video Surveillance
  - Bed alarms
- Further Evaluation
  - Assessment by specialist to identify and address future risk and individualized interventions to promote independence and improve functioning.

Question

- True or False

Equipment use for injury prevention includes a low bed and bed alarms.

Answer

- True

Equipment used for injury prevention includes a low bed and bed alarms. These are commonly utilized for a patient with impaired cognition.

Post Fall Analysis

- Should a fall occur, conduct a post fall assessment/ debriefing :
  - Discover what caused the fall
  - Investigate potential factors:
    - Fall risk factors
    - Activity at the time or prior to fall
    - Time of the day
    - Symptoms before and after the fall
    - Environmental factors
  - Prevent recurrence

Documentation Elements

- Schmid assessment score
- Preventive interventions implemented
- Patient's response to interventions
- E-QVR and addendum fall analysis (post fall)
- Diagnostics studies, if indicated (post fall)
- Initiate/revise the POC
- *For SNF units, a 72 hour documentation is required.* *(DHS Title XXII, 2006)*

Test Question

True or False

The IPOC needs to be revised after a fall incident to incorporate post fall findings.

Answer

- True

The IPOC is initiated upon identifying a patient's risk for falls and revised as needed especially after a fall incident in the hospital.

Keys to Fall Prevention Success

- Simple key messages:
  - *All patients are at risk for falls*
  - *All staff have a role in fall prevention*
- Implement hourly rounding
- Use the Schmid tool to help assess risk
- Customize your plan of care!
- If not working, revise the fall prevention plan

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