# Falls Prevention Strategy

Policy of the "Fall" Season

October-November 2011

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# Did you know…

In Canada:

- Falls are the 6th leading cause of death among older adults.
- Leading cause for injury admissions to Ontario Acute Care Hospitals.
- It is estimated that of the 1 in 40 who are hospitalized as a result of a fall, only 50% will be alive one year later.
- Falls account for up to 84% of inpatient incidents.
- Fall injuries pose a significant burden in terms of loss of life, reduced quality of life and economic cost.

RNAO http://www.rnao.org/Storage/26/2035_168_Falls_Self-LearningPackage_FINAL.pdf

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# The Goals of a Fall Prevention Program are to:

1. Decrease incidence of falls
2. Decrease severity of falls
3. Increase mobility and function
4. Improve environmental safety
5. Provide comprehensive assessment
6. Enhance staff knowledge
7. Improve the patient’s confidence

RNAO http://www.rnao.org/Storage/26/2035_168_Falls_Self-LearningPackage_FINAL.pdf

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# Why do patients fall?

- Combination of factors such as:
  - Unstable gait or balance
  - Urinary frequency
  - Poly-pharmacy/high risk meds (benzodiazepines, etc).
  - Impaired vision
- Poor mobility & confusion often contributing*
- Environmental hazards (eg. wet floor) account for only a small portion of patient falls*

*(National Patient Safety Agency, 2007)

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# Who Falls?

- Who are most vulnerable?
  - Older patients, especially > 80 years.

- What were they doing?
  - Most occur while patients are walking
  - Particularly when using toilet or commode.

- How many falls are witnessed?
  - A minority of falls are witnessed.
  - When witnessed, will staff be able to prevent the patient from falling?

(National Patient Safety Agency 2007)

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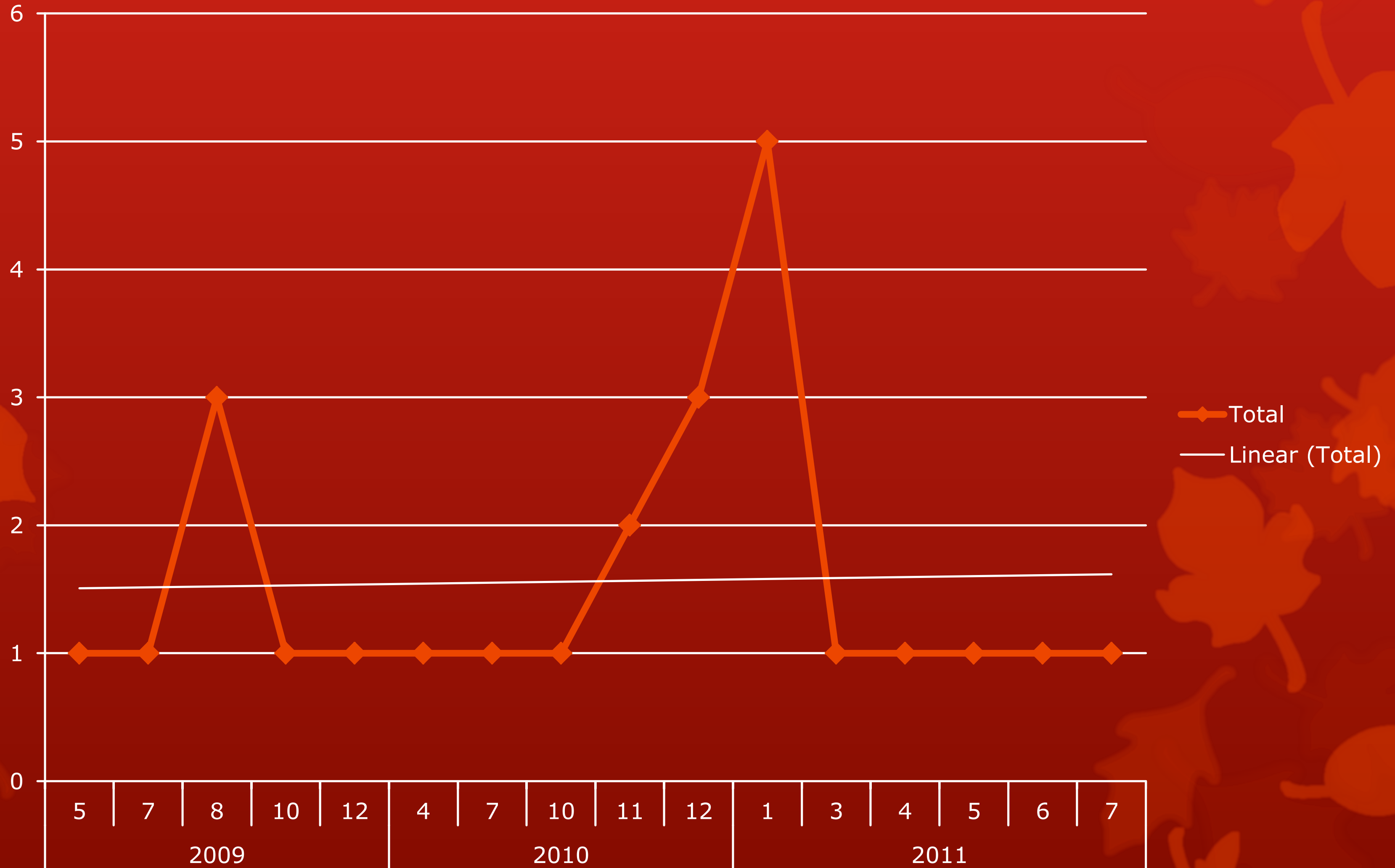
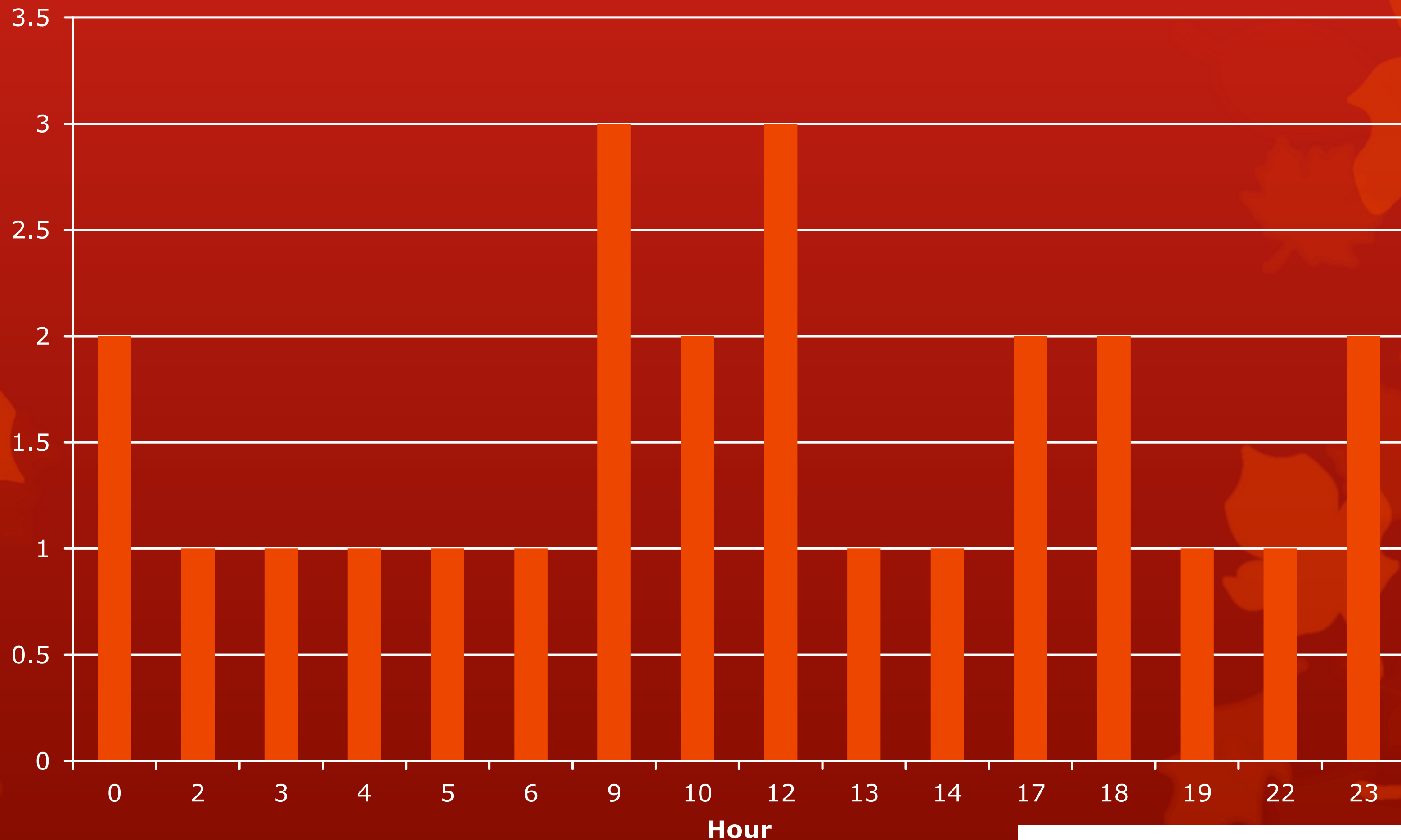
# Falls Statistics in CCTC 2009-2011



# Falls By Hour Stats in CCTC 2009-2011

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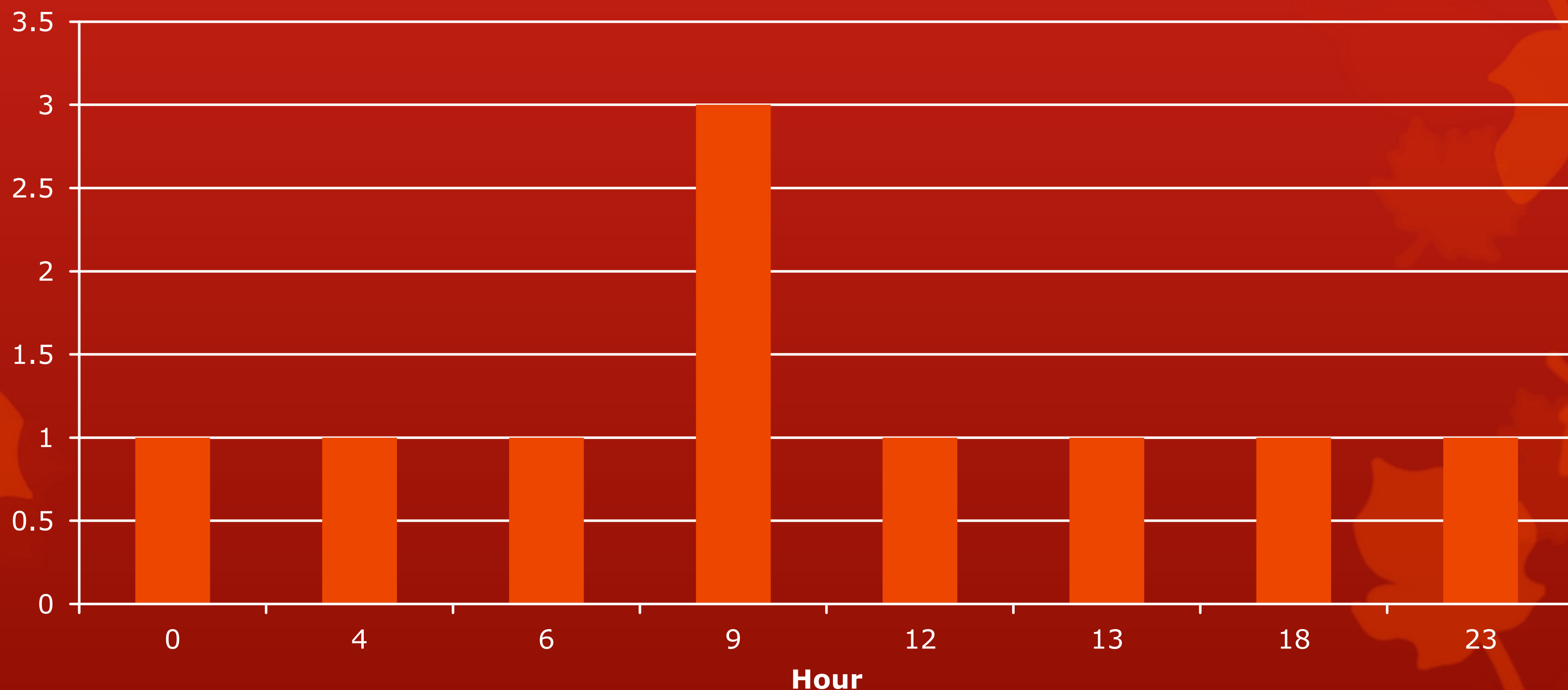
# Falls by Hour – CCTC
## January 1, 2011–September 2011

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# Why Implement Falls Risk Reduction Strategies?

- Falls risk assessment
  - Helps identify risk prone individuals
  - Aims to reduce the number and severity of falls.
- Falls risk assessment consistent with
  - the RNAO Best Practice Guidelines,
  - and meets the requirements of the organizations Required Organizational Practices.

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# LHSC Fall Risk Assessment Team Approach

A. Identify Risk
   - Morse Fall Scale
B. Communicate Risk
   - Bedside signage
   - High Risk Bracelets
   - Kardex; High Risk & Main Interventions identified
C. Review Morse Fall Scale Risk Factors
D. Implement Standard Interventions
E. Conduct High Risk Assessment: Contributing factors
F. Implement High Risk Interventions
G. Provide patient/family education

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# A. Identify Risk

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FALL RISK ASSESSMENT
AND INTERVENTION FLOWSHEET

Complete:
- On Admission or Transfer
- Weekly every Thursday
- After a fall
- Change in condition

**MARK THE SCORE IN THE APPROPRIATE COLUMN FOR THE RISK FACTORS THAT APPLY.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **DATE** (YYYY/MM/DD): | | | | | | | | | |
| **PATIENT UNCONSCIOUS** ☐ **YES** (Low Risk) ☐ **NO** (Complete MFS) | | | | | | | | | |
| **MORSE FALL SCALE (MFS) RISK FACTOR** (see reverse for scoring) | | | | | | | | | |
| **HISTORY OF FALLING** (immediate or within 3 months) | **YES** | **25** | | | | | | | |
| | **NO** | **0** | | | | | | | |
| **SECONDARY DIAGNOSIS** | **YES** | **15** | | | | | | | |
| | **NO** | **0** | | | | | | | |
| **AMBULATORY AID** | Grasps Furniture | **30** | | | | | | | |
| | Uses Crutches / Cane / Walker | **15** | | | | | | | |
| | None / Bedrest / Nurse Assist / Wheelchair | **0** | | | | | | | |
| **IV / SALINE LOCK** | **YES** | **20** | | | | | | | |
| | **NO** | **0** | | | | | | | |
| **GAIT/Transferring** | Impaired (loses balance easy) | **20** | | | | | | | |
| | Weak (no loss of balance) | **10** | | | | | | | |
| | Normal (with/without aid / bedrest / immobile) | **0** | | | | | | | |
| **MENTAL STATUS** | Overestimates / Forgets limitations | **15** | | | | | | | |
| | Oriented to own ability | **0** | | | | | | | |
| **TOTAL FALL RISK SCORE** | | | | | | | | | |
| **INDICATE FALL RISK LEVEL:** LOW (0-24) MODERATE (25-50) HIGH (> 51 OR lower based on clinical judgment) | | | | | | | | | |
| **STANDARD INTERVENTIONS All Risk Levels (✓)** | | | | | | | | | |
| Call system within reach | | | | | | | | | |
| Bed at appropriate height | | | | | | | | | |
| Ensure secure, non-slip footwear with no trailing laces | | | | | | | | | |
| Environment clear/items within reach | | | | | | | | | |
| Walking aids/commodes accessible | | | | | | | | | |
| Assess need for routine toileting | | | | | | | | | |
| Plan exiting/equipment/items on patient's stronger side | | | | | | | | | |
| Patient/Family education | | | | | | | | | |
| **HIGH RISK ASSESSMENT (✓) (Document problem areas on Progress Notes*)** | | | | | | | | | |
| Assess for contributing factors (see reverse) (vision, UTI, urinary frequency, postural BP, delirium) | | | | | | | | | |
| **HIGH RISK INTERVENTIONS (✓) (Document PRIORITY interventions on Patient Care Profile)** | | | | | | | | | |
| HIGH RISK sign posted | | | | | | | | | |
| Nurse assist when mobilizing | | | | | | | | | |
| Night light on | | | | | | | | | |
| Commode at bedside if appropriate | | | | | | | | | |
| "Call Don't Fall" armband | | | | | | | | | |
| Activate bed alarm | | | | | | | | | |
| Indicate number of bedrails required (maximum 3)† | | | | | | | | | |
| Other (specify): | | | | | | | | | |
| | | | | | | | | | |
| **NURSE'S INITIALS** | | | | | | | | | |

**REMEMBER:**
- Consider placement in room near nursing station or in an area of high visibility
- Consider referrals as specific risk factors are identified to reduce risk for falls or repeat falls
- Consider need for medication review by team
- Communicate high risk for fall status at shift report and upon patient transfer to other unit
- Never underestimate the power of clinical judgment

NS5629 (Rev. 2009/04/16)

† The use of bedrails to prevent falls is not recommended (RNAO, 2005). *Based on Morse, J.M, Morse, R.M, & Tylko, S.J. (1989); Morse (2009)

Fall Risk Assessment and Intervention Flowsheet

## Morse Fall Scale

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# Turn sheet over

| MORSE FALLS SCALE SCORING GUIDE | |
|---|---|
| *Note: | If patient unconscious, indicate fall risk level as "Low", omit Morse Falls Scale. Educate family. Reassess fall risk weekly and when condition changes.) |
| **HISTORY OF FALLING:** | |
| 25 points | Immediate history of physiological fall prior to admission (eg. Seizure or impaired gait) or fall within last 3 months of hospitalization. |
| 0 points | No fall |
| **SECONDARY DIAGNOSIS:** | |
| 15 points | Greater than one medical diagnosis listed on chart |
| 0 points | Only one medical diagnosis on chart |
| **AMBULATORY AIDS:** | |
| 30 points | Ambulates by clutching onto furniture for support |
| 15 points | Patient uses crutches, cane, or walker |
| 0 points | Patient ambulates with nurse assistance |
| 0 points | Patient walks without walking aid, uses wheelchair, or is on bedrest and doesn ot get out of bed |
| **INTRAVENOUS THERAPY:** | |
| 20 points | IV or saline lock |
| 0 points | No IV or saline lock |
| **GAIT / TRANSFERRING:** | |
| 20 points | **Impaired Gait:** difficulty rising from chair, head down focuses on ground, loses balance easily. Patient holds tightly to objects/nurse |
| 10 points | **Weak Gait:** patient stooped, may shuffle, but keeps head up and does not lose balance |
| 0 points | **Normal Gait:** head erect, strides safely without hesitation. Normal, bedrest/transfers well to wheelchair walks well with walker/cane/aid/lift aid used. |
| **MENTAL STATUS:** | **Ask patient, "Are you able to go the bathroom alone, or do you need assistance?" Compare patient's answer with your clinical judgment.** |
| 15 points | Overestimates abilities, or forgetful of limitations |
| 0 points | Judges own ability to ambulate accurately *Adapted from Morse (2009) |

## POTENTIAL CONTRIBUTING FACTORS

**Unstable Gait & Balance**
- Consider PT/OT consult
- Encourage pt to call for help for ambulation

**Muscle/strength Weakness**
- Evaluate nutrition, hydration
- Consider dietician consult
- Consider OT/PT consult
- Initiate active/passive ROM exercises of limbs

**Urinary Frequency**
- Assess for UTI
- Review diuretics, renal function
- Reassess IV fluid rate
- Promote safe transfers
- Place commode at bedside prn
- Establish toileting routine

**Orthostatic Hypotension/dizziness, Vertigo**
- Assess BP & Pulse lying & standing
- Review medications
- Consult physician & pharmacist prn

**Pain**
- Assess with pain scale & treat

**Impaired Cognition**
- Assess for dementia, delirium, depression, stroke, hypoxia
- Consider completing CAM (Confusion Assessment Method)
- Consider Geriatric Consult Liaison Team referral
- Assess orientation to time, place and 3 item recall

**Agitation**
- Refer to LHSC Use of Restraint Policy - PCC020 http://appserver.lhsc.on.ca/policy/search_res.php

**Medications**
- Identify meds that ↑ falls risk
  - Polypharmacy
  - Benzodiazepines
  - Psychotropics
  - Diuretics
  - Vasodilators
  - Opioids

**Impaired Vision, Hearing**
- Assess vision, hearing
- Ensure patient using corrective lenses and hearing aids
- Request referrals for vision & hearing testing

**Equipment**
- Ensure good working order and properly used.

## REMEMBER

- Place bedside table & equipment on stronger side
- Have patient exit bed on stronger side
- Assess coordination/balance prior to transfer
- Place items within reach
- Never underestimate the power of clinical judgment

## EDUCATE

- Actively engage patient/family in Fall Prevention
- Teach re: proper footwear & use of assistive devices
- Teach patient use of grab bars
- Provide patient/family education pamphlets as appropriate

- Contains List of Potential Contributing Factors

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# The Morse Fall Scale

Based on 5 main factors

- History of falling
- A secondary diagnosis (higher risk for poly-pharmacy)
- Ambulation aids
- Steadiness of GAIT
- IV or saline lock (fluids…greater need for toileting/risk of tripping on tubing)
- Orientation/awareness of limitations

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# Instructions:

- Unconscious patient
  - Omit Morse Fall Scale,
  - Mark Risk as Low
  - Educate family
  - Reassess as condition changes and weekly.

- History of Falling
  - Check 25 points
    - If patient fell immediately prior to admission
    - If patient fell within past three months
    - Reassess risk + add 25 points if falls in present hospital admission.

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# Instructions

- Secondary Diagnosis
  - Add 15 points if more than one diagnosis on chart.
- Ambulatory Aids
  - Add 30 points if patient clutches onto furniture for support
  - Add 15 points if patient uses cane, crutches or walker.
  - Add 0 points if patient does not need aid, uses wheelchair, is immobile, or is on bedrest.
  - Add 0 points if patient walks with assistance of nurse on consistent basis.

# Instructions

- IV Therapy device/Saline Lock
  - Add  20 points if patient has IV or saline lock
  - Note:  This does not include tube feeds.

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# Instructions

GAIT/transferring

- Means how well the person walks OR transfers in the case that a person is unable to walk.

Add 20 points if patient has an

- **Impaired Gait:** difficulty rising from chair, head down focuses on ground, loses balance easily. Patient holds tightly to objects/nurse

Add 10 points if patient has a

- **Weak Gait**: Patient may be stooped, may shuffle, but keeps head up and does not lose balance, feather touches objects only.

Add 0 points if patient has a

- **Normal Gait:** Head erect, strides safely without hesitation, arms swinging freely at side.
  - OR
    - Is on bedrest
    - Transfers well to wheelchair
    - Lift aid used.

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# Instructions

- Transferring to wheelchair?
  - How well would this person transfer on own?
  - What type of gait is used?
    - Unable + does not attempt to transfer = 0
    - Wriggles, jiggles, slips and slides = impaired = 20
    - Poor transfer/gait if done on own = impaired= 20
    - Able to transfer, but weakly/with weak gait = 10
    - Strong, safe transfer, independently able = 0.

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# Instructions

Mental Status:

- Assess by asking the patient,
  - "Are you able to go to the bathroom alone, or do you need assistance?"
  - Compare patient's answer with patient's actual needs/abilities
- Add 15 points if patient overestimates abilities, or forgetful of limitations
- Add 0 points if patient judges own ability to ambulate accurately

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# Calculate Risk Level

- Low Risk 0-24
- Moderate/High Risk 25 – $\geq$ 51

- Remember:
  - No risk assessment tool can predict 100% of patients who will fall.
  - Never underestimate the power of clinical judgment.

- The main goal of risk assessment is to modify risk factors to lower the risk of falls.

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# Case Study: Ms. G.

- 24 year old female
- Admitted to ICU with septic shock
- No falls since admission
- No previous past medical history
- Ventilated and sedated
- On bedrest
- Multiple IVs in place
- On bedrest/immobile
- Minimally conscious, but immobile

Morse Falls Scoring

- History Fall: 0
- Secondary Dx: 0
- Amb Aid 0
- IV/Saline lock 20
- Gait 0
- Mental Status 0
- Total 20.

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# Case Study:
# Ms. G. *24 hours later*

- 24 year old female
- Admitted to ICU with septic shock
- No falls since admission
- No previous past medical history
- Ventilated and waking
- On bedrest
- Multiple IVs in place
- Restless, attempting to get out of bed
- Delirious

Morse Falls Scoring

- History Fall: 0
- Secondary Dx: 0
- Amb Aid 0
- IV/Saline lock 20
- Gait 20
- Mental Status 15
- Total 55.

# How often do I assess Risk?

- On admission or transfer
- Weekly re-assessment
- After a Fall
- When patient’s condition changes

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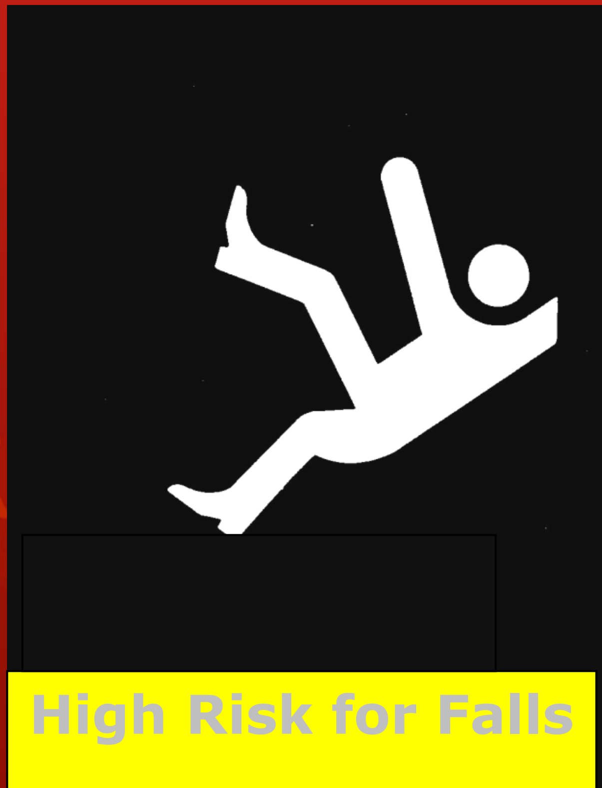
# B. Communicate Risk: Signs

**HIGH RISK**




**NOT HIGH RISK**

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# Communicate Risk: Arm Bands

- Apply Fall Risk Arm Band if:
  - Risk score greater than 24
  - Clinical Judgment if score less than 24
  - (Does this person need assistance when getting up?)
  - Inform patient of Fall Risk status and process

# Communicate Risk: Kardex

- Document priority interventions on Kardex
- Communicate high risk status during report & patient transfer

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# C. Review Risk Factors/Lower Risk History of falling

**Assessment goal:** To prevent recurrence of fall

**Intervention strategy:**

- Develop a strategy to prevent recurrence
- Develop patient-specific fall intervention plan
- Alert staff about the circumstances of the 1st fall
- Conduct rounds every 2 hours to check on Patient

Morse, 2009

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# Secondary Diagnosis

**Assessment goal:** To determine interactions from poly-pharmacy

**Intervention strategy:**

- Consult with physician and pharmacy
- Adjust medications accordingly

Morse, 2009

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# Gait

**Assessment goal:** To assess impairment of gait and balance

**Intervention strategy:**

- Refer to physiotherapy for exercise
- Walk patient regularly and provide a safe route to the bathroom
- Remind patient to use call bell when in need of assistance, to use the handrail and plan a route
- Inform family about limitation and plan for fall intervention

Morse, 2009

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# Ambulatory Aid

**Assessment goal:** To assess appropriate aids

**Intervention strategy:**

- If wheelchair use observe transferring technique
- Provide appropriate aids, and that they are used correctly
- Avoid "rushing to the bathroom" by providing bowel and bladder routine

Morse, 2009

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# IV

**Assessment goal:** To maximize safe ambulation, reduce urinary urgency

**Intervention strategy:**

- Assess fluid balance, hypotension
- If using pole as walking aid, provide walker and assist with ambulation
- Remind patient of physical limitations
- Provide bladder routine if urinary urgency present

Morse, 2009

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# Mental status

**Assessment goal:** To improve orientation and acceptance of changed abilities

**Intervention strategy:**

- Observe frequently, place patient in room by nursing station
- Frequently reorientation and remind
- Do not leave unattended in diagnostic areas
- Implement bowel and bladder program
- Involve family for observations and planning care

Morse, 2009

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# D. Implement Standard Interventions (Flowsheet Checklist)

- Call system within reach
- Bed at appropriate height
- Ensure secure, non-slip footwear with no trailing laces
- Environment clear/items within reach
- Walking aids/commodes accessible
- Assess need for routine toileting
- Plan exiting/equipment/items on patient's stronger side
- Patient/family education

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# E. Conduct High Risk Assessment

- Assess for contributing factors
- Document significant issues on progress notes
  - Impaired vision &/or impaired hearing
  - UTI
  - Urinary frequency
  - Postural hypotension, vertigo
  - Muscle weakness and unsteady gait/ balance
  - Delirium
  - Pain
  - Medications

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# F. Implement High risk interventions as appropriate

- HIGH RISK sign posted
- Nurse assist when mobilizing
- Night light on
- Commode at bedside if appropriate
- “Call Don’t Fall” armband/verbal consent obtained
- Activate bed alarm
- Indicate number of bedrails required (maximum 3)

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# G. Educate patient and family

- Actively engage patient/family in Fall Prevention
- Provide LHSC Letter to Patient/Family (All patients- admission package).
- Tell patient regarding their risk status
  - Remind them using the "Call Don't Fall" Motto
  - Obtain verbal consent to apply yellow armband.
- Teach re: fall prevention strategies, eg. proper footwear & use of assistive devices
- Assist patient/family in obtaining education pamphlets on fall prevention

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# Remember the ABC's of Lowering Fall Risk

**CALL, DON'T FALL**

- ASSIST with ambulation
- Initiate BATHROOM routine
- Remind patient to CALL for assistance

- If patient unable to call, increase observation.

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# LHSC experience…so far

- Outcomes after first 18 months.
  - 15% reduction in Falls since Falls prevention strategies have begun
  - 62% reduction of major patient falls

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# References


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