CONNECTICUT ASSOCIATION FOR HEALTHCARE AT HOME℠

BEST PRACTICE TOOLKIT: Falls Prevention Program

This toolkit has been developed by the Association's Future of Healthcare at Home Task Force and is intended to be utilized as a guide to assist agencies in implementing or further developing their Falls Prevention Program. Throughout the toolkit are links to best practice resources for your use.

Definition of a Fall: Unintended movement from a higher level to a lower level surface for both witnessed and unwitnessed incidents. This includes physical hands-on assistance to lower someone to a surface who is in the act of falling.

Program Standard:
Agency will have a fall program in place that includes:

- Incident Reporting and Documentation Policy
- A validated fall risk assessment
- Identification and stratification (Identify patient-centered goals and deficits that are realistic and consistent based on physical and cognitive abilities)
- Referral for therapy and goals/interventions to minimize fall risk and fall events.

Tier 1 **= Basic Fall Prevention Program: Person-Centered Approach**

Tier 2 **= Advanced Fall Prevention Program: Agency Population Approach; (includes all of Tier 1)**

Tier 3 **= Advanced Fall Prevention Program: Community Approach; (includes all of Tier 1 and Tier 2)**

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BEST PRACTICE TOOLKIT: Falls Prevention Program

Tier 1: Basic Fall Prevention Program – Person-Centered Approach

Risk Assessment

1. **Assess patients for risk of falling using a standard/validated risk assessment tool**
   - i) Examples include: APTA tool box, CDC STEADI Toolkit
   - ii) MAHC 10: Only multi-factorial validated tool
     - a. May use one of the following in addition to the MAHC 10 to validate risk
       - i. TUG: Ambulatory patients who don't need manual assist
       - ii. Tinetti: Ambulatory patients who don't need manual assist (except Parkinson's Disease)
       - iii. Functional reach: If able to stand unassisted but need manual assist to ambulate; May use sitting FR if need manual assist to maintain stand.
       - iv. BERG: Most independently predictive tool for fall risk but lengthy (20min) – Done by therapy
2. **For Nursing, recommend MAHC-10 on all and TUG if able to ambulate without manual assist**
   - i) Focus on polypharmacy and med management therapy and orthostatic BPs (use Beers criteria list) - LINK
   - ii) Refer to therapy with patient specific reason
3. **For Therapy, recommend MAHC-10 (if therapy only) and appropriate risk tool based on above list**
   - i) Focus on more extensive balance assessment tool
4. **Every visit, all staff ask: "Have you had any falls since our last visit?" (Explore who, what, where, when, why)**

Interventions

1. CT Coalition for Falls Prevention - A Guide for Clinicians (full book – recommend printing & organizing per agency preference)
2. Home safety evaluation —**CDC**
3. **Patient/Family Caregiver teaching**
4. **Consider DME, ERS, TM**
5. YouTube video including MI techniques
6. **Referrals to Therapy**
   - i) PT: balance and gait, dizziness, strength training, transfers, equipment needs, energy conservation
   - ii) OT: cognitive changes, ADLs/IADLs, perceptual difficulties, energy conservation, low vision
   - iii) ST: cognitive changes (non-dementia), communication strategies, medication strategies, nutritional issues
7. **Referral to Social Work:** Resources for additional services/equipment, LTC planning options, counseling for depression, anxiety, isolation, hoarding
8. **Post-Fall Assessment and Follow-up per agency policy**

Specific to Hospice

Hospice Falls Prevention: Risk Assessment & Interventions

i) MAHC for all (others as appropriate)
ii) Interventions to prevent or minimize further falls
  a. Med review on case-by-case basis: consider med options but EOL symptom management meds as a rule present fall risk.
  a. Therapy not for rehab but safety and family teaching
    i. Transfer training
    ii. Significant family and caregiver teaching
    iii. DME
      - Examples include: scoop mattress, mattress on floor
  b. Stats: falls by staff, by team, by dx, by setting – root cause analysis
iii) Data supports more frequent falls in NH's and ALSAs esp. dementia population
      - Importance of Communication, falls reporting, and care coordination

Tier 2: Advanced Fall Prevention Program – Agency Population Approach

1. **Falls reporting (to Falls champion designee or team):**

i) Any falls since last visit? (all staff)—witnessed and unwitnessed by staff
ii) Consider Falls hotline or internal process to report falls (incident reports, OASIS data)
iii) Post-fall assessment by licensed staff, root cause analysis, education to pt/CG on importance of falls reporting

2. **Falls reporting: notify other providers of fall risk**

3. **Falls prevention processes/interventions:**

i) Safety huddles/moments to discuss high risk cases
ii) Root cause analysis and person-ctrd interventions
iii) Consider pharmacy consult

4. **Falls tracking/trending real time**
   - i) Trending overall statistics
     - (a) by clinician, by team, by discipline
     - (b) by diagnoses, reasons, medications
   - ii) Track days since last fall
   - iii) Patterns of root cause
   - iv) Repeat fallers
   - v) Audit records and follow up

5. **Falls education—staff and patient/CG**
   - i) Trending data, outcomes, OASIS data, hospitalization rates
   - ii) Medications (reinforce Beers criteria list)
   - iii) Reporting Falls
   - iv) Low vision/other risks
   - v) Gait belts/safe transfers
   - vi) Environment
   - vii) Resource list

Tier 3: Advanced Fall Prevention Program – Community Approach

1. **Falls Prevention education and screening to senior housing, community groups, AARP**
2. **Balance/exercise classes for community fall risk population – OTAGO Exercise Program, Tai Chi**
3. **Develop standard hand-off across care continuum: hospital, nursing home, home health, and community physician, outpatient care**
4. **Referrals to community programs identifying fall risk and prevention**
5. **Market Falls programs externally using outcomes data to form partnerships (ACOs, DSS models)**
6. **Safety huddles/Falls team (EG communities of care)**
7. **Screening/tracking/trending stats/outcomes for community populations (reduction in falls, injuries, hospitalizations)**