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)
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
BEST PRACTICE TOOLKIT: Falls Prevention Program

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)