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| **Fall Risk Assessment and Prevention** | **Last Revision:**  |  September 4, 2014 |
| **Applies to the THA Group of Companies:**  | * Island Health Care
* Island Hospice
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|  | **Included in the following THA Manual:** | * Administrative Policy and Procedure Manual
* II – Provision of Care, Treatment & Service
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**PURPOSE**

To assess and address potential risks in order to actively prevent patient falls.

**PROCEDURE**

1. A fall risk assessment will be completed by the clinician;
	1. At start of care
	2. At re-certification
	3. At resumption of care
	4. Following a reported fall
2. The MAHC - 10 (Missouri Alliance for Home Care) multi-factor fall risk assessment is incorporated into the THA Group point of care system. This tool has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls.
3. The MAHC – 10 Fall Risk Assessment includes a standard response scale; a score of 4 or more indicates the patient is at risk for falls. The standard and high-risk fall prevention instructions/interventions will be included in the SOC packet.
4. Standard fall prevention goals and interventions will be implemented by all clinicians at start of care for allpatients. Clinicians providing care to the patient will review safety precautions included in the start of care manual.
5. When a patient is identified as high risk for falls, all clinicians caring for that patient will implement appropriate fall risk interventions and precautions and teach/review fall prevention interventions (see attached instructions/interventions) to the patient and caregiver during home visits and during telephonic visits.

#### Standard Fall Prevention Interventions

###### **Nursing Staff**

* Assess patient’s fall risk upon admission, change in status, transfer to another unit and discharge.
* Assess the patient’s coordination and balance before assisting with transfer and mobility activities.
* Implement bowel and bladder programs to decrease urgency and incontinence as appropriate.
* Encourage the use of treaded socks for all patients if not wearing shoes.
* Evaluate and obtain orders for pain treatment.
* Evaluate medication profile for fall risk.
* Evaluate for orthostatic hypotension.

###### **All Staff**

* Approach patient towards unaffected side (if applicable) to maximize participation in care.
* Transfer patient towards stronger side.

###### **Equipment**

* Lock all moveable equipment before transferring patients.
* Individualize equipment specific to patient needs.

###### **Education**

* Actively engage patient and family (or caregivers) in all aspects of Fall Prevention Program
* Instruct patient in all activities prior to initiating assistive devices.
* Teach patient/caregivers use of grab bars.
* Provide home safety evaluation and suggestions (i.e. eliminate spills, clutter, electrical cords, and unnecessary equipment).
* Instruct patient in medication time/dose, side effects, and interactions with food/medications.

###### **Environment**

* Place patient care articles within reach.
* Provide physically safe environment as assessed above.
* Provide adequate lighting.

###### **Therapy Staff**

* Evaluate and treat gait changes, postural instability, and spasticity.
* Initiate treatment for impaired vision, hearing.
* Assess and treat impaired central processing (dementia, stroke, perception)

#### High-Risk Fall Prevention Interventions

###### **Nursing/Therapy Staff**

* Consider use of technology for fall prevention. (Non-skid floor mat, raised edge mattress, handrails, grab bars, lifts, etc.)
* Clear patient environment of all hazards
* Review medications for fall risk and adjust with physician as indicated.
* Evaluate and obtain treatment for pain.
* Evaluate circumstances surrounding fall for extrinsic and intrinsic contributing factors.
* Initiate patient evaluation for gait, balance, and transfer mobility.
* Provide transfer and mobility aides.
* Initiate individual exercise education.

###### **Education**

* Exercise
* Nutrition
* Home Safety
* Plan for emergency fall notification procedure.

**The THA Group “Step Forward” Fall Prevention Program Algorithm**

Purpose: A guide for the THA Group clinicians to help them implement the “Step Forward” Fall Prevention program interventions correctly.

Design a customized HEP for the patient to improve balance

Recommend the use of color and contrast; check that there is good illumination at the house; ask patient to see ophthalmologist regularly; clear walkways from clutter.

If patient has vestibular symptoms or existing eye disorders (cataracts, glaucoma, macular degeneration, diabetic retinopathy, field cut) perform a more detailed vision assessment.

Check if systolic BP drops 20 and diastolic 10 mm Hg within 3 minutes of standing when compared with BP from sitting or supine. If it does, provide disease management education to the patient about orthostatic hypotension.

Educate patient about medications which affect balance such as psychotropic medications

Complete Home Safety Checklist form and give it to the patient

For persistent symtoms or for cupulolithiasis of anterior and posterior canals try Semont

If symptoms don’t resolve try habituation exercises.

For BPPV use canalith repositioning first

Report results to branch therapist who is assigned to do vestibular treatments

Assess vestibular system (if patient has vestibular symptoms) by performing Motion Sensitivity Quotient test.

Provide toileting training to incontinent patients. Include instructions about timed voiding.

If unsafe refer to OT

ST will report results to team

If impaired refer to ST for MMSE

Review MSW handout with patient about available community resources

Assess near and far vision

Assess ADLs and IADLs

If high fall risk refer to “*Step Forward*” fall prevention program

Reconcile medications

Assess need for DME/mobility aids/home modifications. Identify environmental risk factors

Assess safety awareness

**High Risk of Fall** Tinetti < 18 TUG > 14 seconds MAHC ≥ 4 Recent Fall Unsafe ADL/IADL

Use MAHC for non-ambulatory patients

Use TUG or Tinetti for ambulatory patients

Complete Fall Risk assessment at: 1. Start of care 2. Re-certification. 3. ROC 4. Following a reported fall.