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Falls Risk Screening and Assessment

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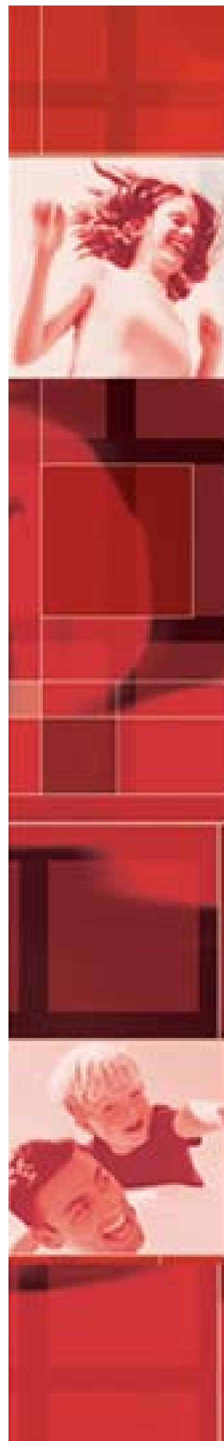

Falls

- **A fall** is an event which results in a person inadvertently coming to rest on the ground, the floor or other lower level

- This can be from standing, bed or chair.

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Cost

Most practitioners are conscientious and well intentioned,

Nether less…………

We make wrong plans, we harm patients with 10% of admissions, the harm is permanent or severe in 2 %, death results in 1/300 patients which is 4x the road toll and

The harm costs up to $ 1 million per hour

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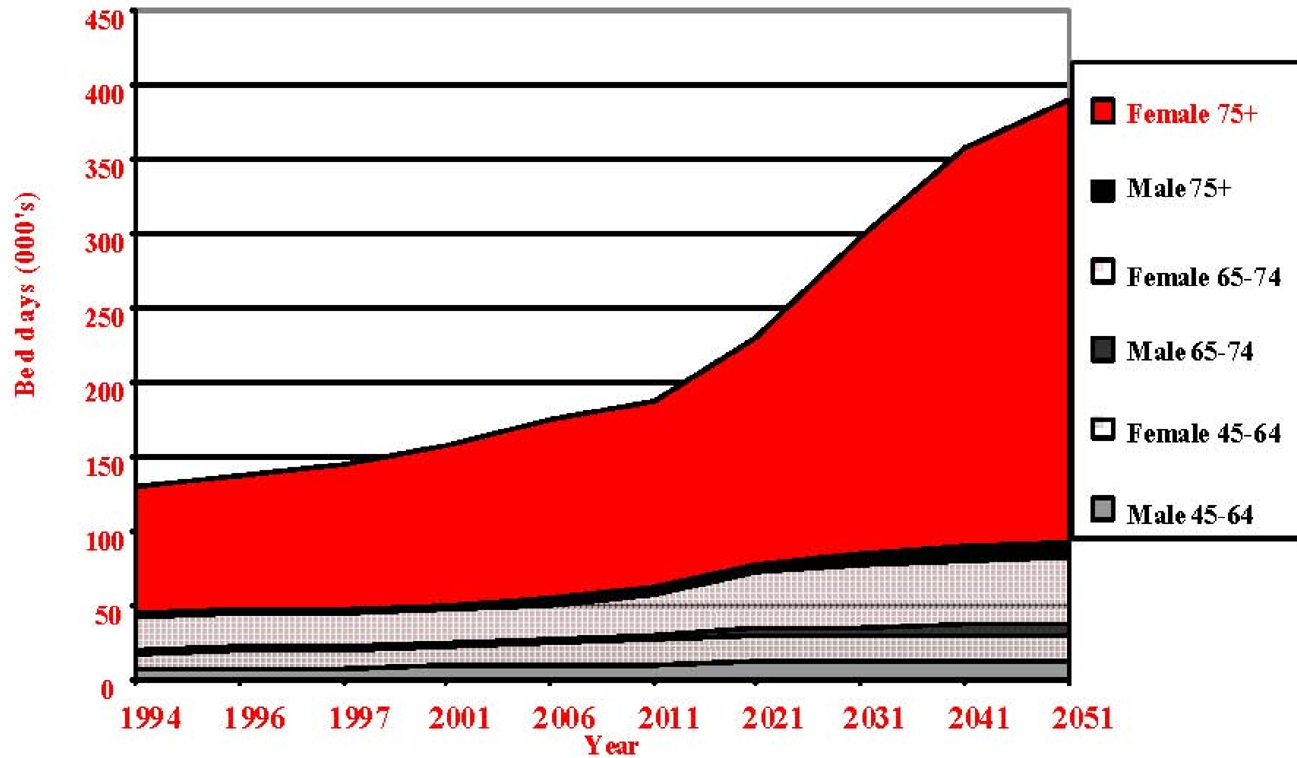
Projected bed days



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Factors

- Intrinsic (personal)
  - Insufficient exercise & maintenance of strength
  - Impaired balance & gait
  - Deterioration of vision
  - Multiple medications
  - Chronic medical conditions (eg. stroke; Parkinson's; osteoporosis)
  - Impaired cognition
  - Prior history of falling

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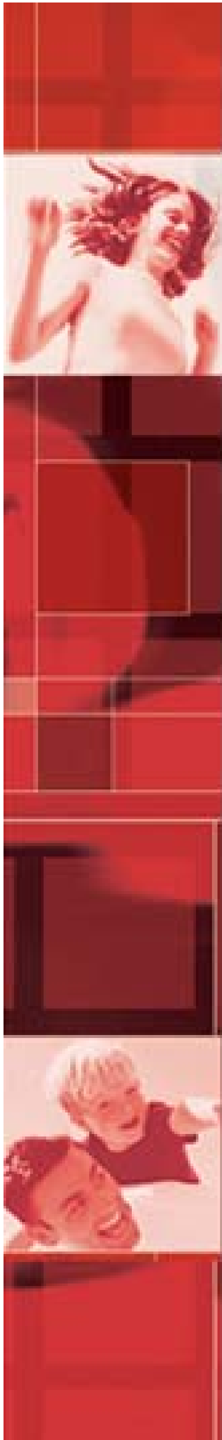

Factors

- Extrinsic (environmental)
  - Inadequate lighting
  - Uneven, slippery or loose floor surfaces
  - Poor step & stairway design (eg. no handrails)
  - Unsecured floor coverings & rugs
  - Inadequate footwear
  - Obtruding cords & cables

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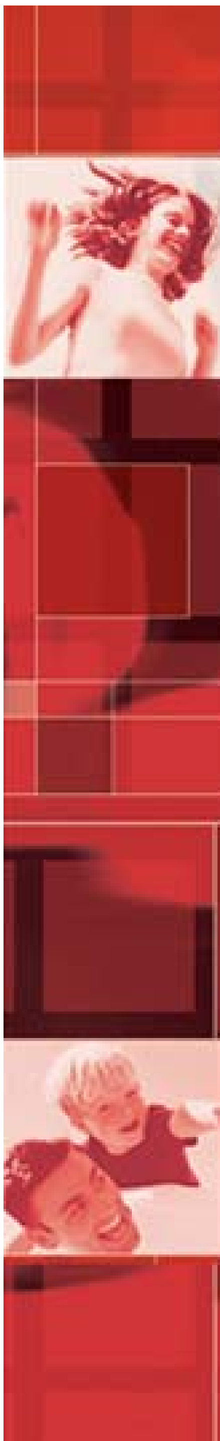

Famous Fallers

- Paula Abdul is known for her bubbly but benign feedback to contestants on the hit show, American Idol. On May 22, 2007, however, the gorgeous and spunky media diva fell while trying not to step on a much smaller set of toes – those of her pet Chihuahua. While “chubby little Tulip” escaped unscathed, the forty-four year-old former cheerleader suffered bruising from her arm to her hip, a fractured toe and a broken nose.

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Famous Fallers

- Dr. Robert Atkins, the "weight-loss guru" that brought to us the famous "Atkins diet" died on April 17, 2003 in New York from head injuries suffered in a fall near his office. He was 72.

- Dave Freeman, whose book "100 Things To Do Before You Die" inspired the recent film "The Bucket List", died after hitting his head from a fall at his home. He was 47.

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Falls in hospital

- Most people who have a fall in hospital are over 65 years of age
- Most falls are unwitnessed
- Most falls occur around the bed area
- 50% will result in injury

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Risk factors for falls in hospital

- Patient has a history of **falls**
- Patient is **confused or agitated:**
  - – can be long standing e.g. dementia (unfamiliar environment etc)
  - – or can be acute e.g. delirium, change in neurologic state
- **Gait instability/Unsafe mobility** and transfers:
  - – May have a walking aid such as a frame or a stick or newly diagnosed condition e.g. stroke or amputation

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Risk factors for falls in hospital

- **Urinary incontinence/ frequency**
- Takes **medications** associated with increased risk of falls
  - e.g. sedatives, hypnotics, diuretics, antihypertensives

  (polypharmacy)
- Has **poor vision**, such that everyday function in the ward is impaired

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- **Death**
- Serious injury
- Increased stay in hospital
- Loss of independence on discharge
- RACF

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What to do?

- Risk screen all adult patients on admission to wards
- Identification of patients at high risk of falls injury
- Implementation of specific and targeted risk reduction strategies for patients at high risk of falls injury
- Documentation of falls risk and injury in the medical records.
- Reporting, investigation and monitoring of risks.

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What is happening in HNE?

- Emergency Department- Three question screen to identify falls risk (FROP. com screen)

- Inpatient setting Acute/Sub acute- Six question screen to identify risk and create referral and management plan

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ED

- On presentation to ED screen all people 65yrs and older(45+Aboriginal and Torres Strait Islander) and /or presenting following a fall
- Include the current ED falls presentation and include the terms “slips”, “trips”, “faints” and “any other accidents” to elicit a complete falls history.
- The triage code is *W19* Fall, unspecified

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ED

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EMERGENCY DEPARTMENT

Adult Assessment, Treatment and Observation Form

PLEASE USE GUMMED LABEL IF AVAILABLE	
SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
DATE OF BIRTH	M.O.

FALLS RISK SCREEN: Screen all people post fall and 65 years and older (45yrs and older Aboriginal &Torres Strait Islander people)

Falls History:	Score 0-3 *(clearly circle responses)*	Score
1. Number of falls in the past 12 months	▪ None ▪ 1 Fall ▪ 2 Falls ▪ 3 or more falls	0 1 2 3
Function ADL Status ** if no fall in the last 12 months, rate current function**		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?	▪ None *(completely independent)* ▪ Supervision ▪ Some assistance required ▪ Completely dependent	0 1 2 3
Balance		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance? ▪ *Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid.* ▪ *Do not base on self report* ▪ *If level fluctuates, tick score 3.* ▪ *If the person is unable to walk due to injury, score 3*	▪ No unsteadiness observed ▪ Yes minimally unsteady ▪ Yes, moderately unsteady *(needs supervision)* ▪ Yes, consistently & severely unsteady *(constant hands on assistance)*	0 1 2 3
FALLS RISK MANAGEMENT:	**TOTAL SCORE:**	

0-3 Low Risk	**D/C Pathway:** *Refer to the following services* ☐ Community physical activity program ☐ LMO	**Admission Pathway:** *Ensure staff are aware of completed falls risk screen and strategies implemented*
4-9 High Risk *National Aging Research Institute 2007*	**D/C Pathway:** *Referral pathway relevant to local site* ☐ ASET review ☐ Community Health ☐ CAPAC ☐ LMO ☐ DVA ☐ Falls Clinic *(Newcastle only)*	**Admission Pathway:** ☐ ASET review ☐ Physio, OT, SW ☐ Accurate handover to ward staff

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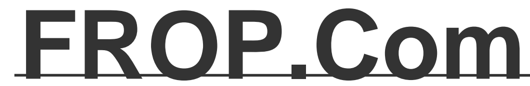

FROP.Com

- Question 1- FALL HISTORY
- Question 2-FUNCTIONAL PROFILE
- Question 3- BALANCE

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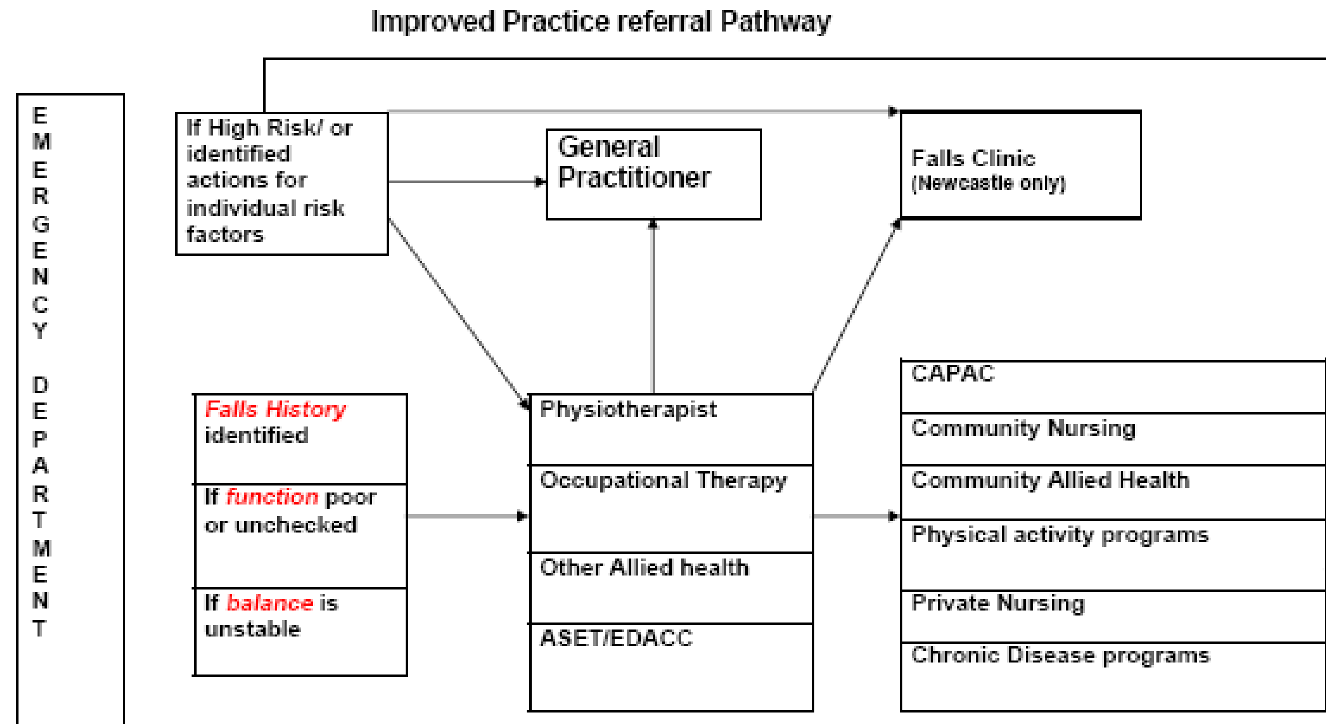
Flow chart



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Inpatient

Tool for use

in the inpatient

setting

Modified Ontario

STRATIFY with

Sydney Scoring

HNE Adult Inpatient Falls Risk Screening Tool Ontario Modified STRATIFY –Sydney Scoring (SS)			Date __/__/___
Item	**Falls Risk Screening Assessment**	**Value**	**Score:**
1. History of falls.	Did the patient present to hospital with a fall or have they fallen since admission? No □ Yes □ If not, has the patient fallen within the last 2 months? No □ Yes □	Yes to any = 6	
2. Mental Status	Is the patient confused (i.e. unable to make purposeful decisions, disorganised thinking and memory impairment**?** No □ Yes □ Is the patient disorientated (i.e. lacking awareness, being mistaken about time, place or person) No □ Yes □ Is the patient agitated (i.e. fearful affect, frequent movements and anxious) No □ Yes □	Yes to any = 14	
3. Vision	Does the patient: -Require eyeglasses continually? No □ Yes □ -Report blurred vision? No □ Yes □ -Have glaucoma, cataracts, macular degeneration? No □ Yes □	Yes to any = 1	
4. Toileting	Are there any alterations in urination (i.e. frequency urgency, incontinence, nocturia)? No □ Yes □	Yes = 2	
5. Transfer Score **(TS)** [means from bed to chair and back]	Independent use of aids to be independent allowed? No □ Yes □ Minor help, one person easily or needs supervision for safety? No □ Yes □ Major help – one strong skilled helper or two normal people; physically can sit? No □ Yes □ Unable/no sitting balance; mechanical lift? No □ Yes □	Yes = 0 1 2 3	
6. Mobility score **(MS)**	Independent (but may use any aid e.g. cane)? No □ Yes □ Walks with help of one person (verbal or physical)? No □ Yes □ Wheelchair independent including corners? No □ Yes □ Immobile? No □ Yes □	Yes = 0 1 2 3	
	Add transfer score **(TS)** and mobility score **(MS)** =		
As validated tool patient at risk if total score ≥ 9 Action total score and follow risk recommendations as per level of risk 0-5 Low risk --------- 6-16 Medium risk --------- 17 -30 High risk		TOTAL SCORE = RISK LEVEL =	Print: Sign: Designate: Time:

Actions: □ Patient identified at risk □ Handover "Falls Risk" to all personnel caring for patient □ Enable Falls Alert on iPM □ Implement Falls Prevention Care Plan □ Document falls management plan in medical record □ Referral to Allied Health for patients "at risk" of falls

General Falls Risk Management Principles: NSW Health PD 2005_353 Management Policy to reduce Fall Injury Among Older People and HNE PCP Assessment of Falls in Adults on Admission to Acute Inpatient Care (2009)

Rescore after significant change in patient's condition or environment:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Score:									
Risk Category:									
Management Plan:									
Signature / Des:									
Time:									

DRAFT

Question 1

Item	Falls Risk Screening Assessment	Value	Score
1. History of falls.	**Did the patient present to hospital with a fall or have they fallen since admission?** No □ Yes □ **If not, has the patient fallen within the last 2 months?** No □ Yes □	Yes to any = 6	

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Question 2

Item	Falls Risk Screening Assessment	Value	Score
2. Mental status	**Is the patient confused?** (i.e., unable to make purposeful decisions, disorganised thinking and memory impairment) No□ Yes □ **Is the patient disorientated?** (i.e. lacking awareness, being mistaken about time, place or person). No □ Yes □ **Is the patient agitated?** (i.e., fearful, affect, frequent movements, and anxious) No □ Yes □	Yes to any = 14	

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Question 3

Item	Falls Risk Screening Assessment	Value	Score
3. Vision	**Does the patient require eyeglasses continually?** No □ Yes □ **Does the patient report blurred vision** No □ Yes □ **Does the patient have glaucoma, cataracts or macular degeneration?** No□ Yes□	Yes to any = 1	

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Question 4

Item	Falls Risk Screening Assessment	Value	Score
4. Toileting	**Are there any alterations in urination?** (i.e., frequency urgency, incontinence, nocturia) No □ Yes □	Yes = 2	

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Question 5

Item	Falls Risk Screening Assessment	Value		Score
5. Transfer score (TS) [means from bed to chair and back].	□Independent use of aids to be independent is allowed No □ Yes □ □Minor help one person easily or needs supervision for safety No □ Yes □ □Major help – one strong skilled helper of two normal people; physical – can sit No □ Yes □ □Unable/ no sitting balance; mechanical lift No □ Yes □	0 1 2 3	Add **Transfer score** (TS) and **Mobility score** (MS)	(Score totalled)

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Question 6

Item	Falls Risk Screening Assessment	Value		Score
6. Mobility Score (MS)	□Independent (but may use any aid, e.g., cane) □Walks with help of one person (verbal or physical) □ Wheelchair independent including corners, etc. □ Immobile	0 1 2 3	If value total between 0-3, then score =0 If values total between 4-6, then score = 7	

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Question 5&6

Item	Falls Risk Screening Assessment	Value		Score
5. Transfer score (TS) [means from bed to chair and back].	□Independent use of aids to be independent is allowed	0	**Add (TS) + (MS)**	(Score totalled)
	□Minor help one person easily or needs supervision for safety	1	***If total value is between 0-3, then score = 0***	
	□Major help – one strong skilled helper of two normal people; physical – can si	2		
	□Unable/ no sitting balance; mechanical lift	3		
6. Mobility Score (MS)	□Independent (but may use any aid, e.g., cane)	0	***If total value is between 4-6, then score = 7***	
	□Walks with help of one person (verbal or physical)	1		
	□ Wheelchair independent including corners, etc.	2		
	□ Immobile	3		

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Risk Score

- Low risk 0-5 points
- Medium risk 6-16 points
- High risk 17-30 points

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All level of risk-low, med, high

- Orientation to the bed area and ward facilities, ward routine and staff.
- Lower bed if possible, except during direct clinical care. Ensure brakes are on.
- Keep bedrails lowered except at appropriate patient request and record reason in medical record.
- Place call bell and side table within reach, and instruct patient to call for assistance as required.
- Clear area of hazards, spills, clutter, unstable furniture.

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All level of risk

- Ensure safe footwear when mobilising i.e. well-fitted shoes or non-slip socks.
- Place walking aids within reach.
- Clothing to be good fitting and of appropriate length.
- Fall prevention brochure provided to patient/carer.
- Ensure patient has access to adequate nutrition and hydration.
- Medication review and medical review.
- Ensure patient has glasses and hearing aid if required.

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Medium risk

All previous risk recommendations plus-

- Supervise patient during mobilisation.
- Supervise patient during personal care and toileting.
- Individualised toileting plan.
- Referral to physiotherapy for mobility disorders, and occupational therapy for difficulties in ADL, as per facility policy.
- For over 65s – consider bone protection, medication review: consider vitamin D and calcium supplementation.

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High risk

All previous risk recommendations plus-

- Do not leave patient unattended during planned toileting, self care or mobilising.
- Locate patient close to the nurses station, or in 4 bedded room to increase observation
- Use lo-lo/hi-lo bed where available. Ensure bed in lowest position when patient unattended.
- Consider specialling patient, sitter or family to increase frequency of observation – particularly if confused/delirious.
- Consider use of hip protectors.

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Post fall-CEC documents

POST FALL ASSESSMENT & MANAGEMENT

FALLS AND HITS HEAD	FALLS AND DOES NOT HIT HEAD	UNWITNESSED FALL
SPECIAL CONSIDERATION – Patients on anticoagulant and/or antiplatelet therapy and patients with a known coagulopathy are at an increased risk of intracranial haemorrhage. Anticoagulants include: Warfarin, Heparin, Enoxaparin (Clexane), Dalteparin (Fragmin). Antiplatelet drugs include: Aspirin, Clopidogrel, Aspirin+Dipyridamole (Asasantin). Alcoholic patients are considered coagulopathic.		
• Do not move initially • Call for assistance • Immobilise Cervical Spine and examine for injuries • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, Blood Sugar Level (BSL)) • Neurological Observations - initial Glasgow Coma Scale (GCS) • Observe for change in the level of consciousness, headache, amnesia or vomiting • Clean and dress any wounds	Potential Injuries: fracture, soft tissue injury or no observable injury. • Do not move initially • Call for assistance • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) • Clean and dress any wounds	Potential Injuries: Head or neck injury, fracture, soft tissue injury or no observable injury. • Do not move initially • Call for assistance • Immobilise Cervical Spine and examine for injuries • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) • Neurological Observations - initial Glasgow Coma Scale (GCS) • Observe for change in the level of consciousness, headache, amnesia or vomiting • Clean and dress any wounds
Contact Medical Officer for review	Contact Medical Officer for review	Contact Medical Officer for review
Consider need for analgesia	Consider need for analgesia	Consider need for analgesia
Liaise for appropriate test (consider CT Scan if patient has any high risk factors, see Section 6 of *NSW Health PD2008_0081 Head Injury*)	Liaise for appropriate test (eg X rays)	Liaise for appropriate test (eg CT Scan if patient has any high risk factors, see Section 6 of *NSW Health PD2008_0081 Head Injury*)
Notify registrar / consultant (if required)	Notify registrar / consultant (if required)	Notify registrar / consultant (if required)
Observations • Record vital signs and neurological observations hourly for 4 hours then review • Continue observations at least 4 hourly for 24 hours or as required • Notify MO immediately if any change in observations	**Observations** Monitor vital signs for 24 hours	**Observations** • Record vital signs and neurological observations hourly for 4 hours then review • Continue observations at least 4 hourly for 24 hours or as required • Notify MO immediately if any change in observations
Notify family	Notify family	Notify family
If not already flagged as high risk of fall injury, flag as per hospital protocol	If not already flagged as high risk of fall injury, flag as per hospital protocol	If not already flagged as high risk of fall injury, flag as per hospital protocol
IIMS report	IIMS report	IIMS report
Post Fall review Document in medical record strategies implemented	**Post Fall Review** Document in medical record strategies implemented	**Post Fall review** Document in medical record strategies implemented
Reassess Falls Risk Status – Refer to relevant staff to review, update care plan and implement Falls prevention strategies		
Communication – All staff involved in the care of the patient to be informed of incident outcome and revised care plan		

ACKNOWLEDGMENTS:
1. Adapted From RNS and RHS Policy Per RNS2005/46
2. Hook, ML., Winchel, S (2006) Fall Related Injuries in Acute Care: Reducing the Risk of Harm, MEDSURG Nursing, Vol 15/No.6
3. NSW Department of Health, Policy Directive: *Initial Management of Closed Health Injury in Adults, PD2008_0081 Head Injury*, 2008.
4. NSW Institute of Trauma and Injury Management www.itim.nsw.gov.au

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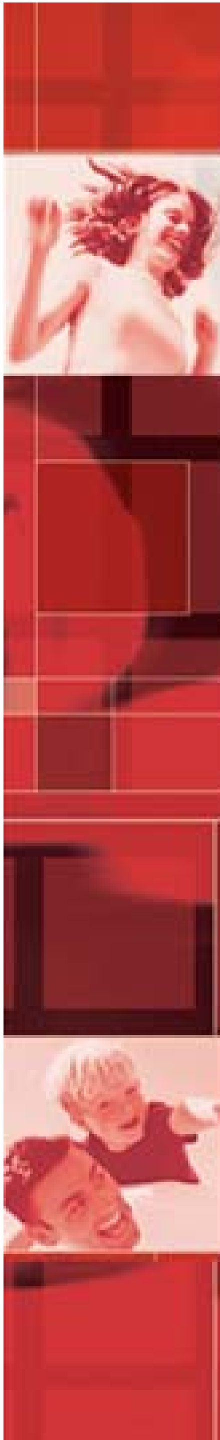

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