FALLS PREVENTION TRAINING FOR NURSE DELEGATORS

Injury and Violence Prevention

Washington State Department of Health

Falls Prevention

Nurse Delegation Conference

October 19th, 2018

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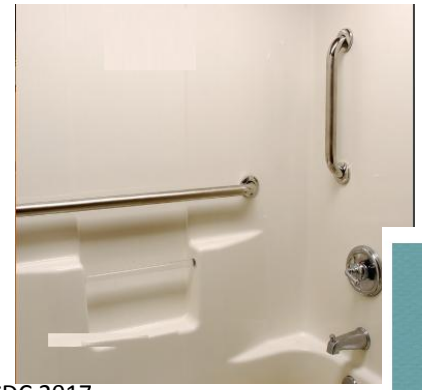
Injury and Violence Prevention

Presentation Overview

- **Falls Are Preventable**
- **Falls Risk Trivia**
- **Risk Factors and Screening Tools**
- **How to Modify Risk Factors**
- **Case Study**

Falls **Are** Preventable

Home Safety

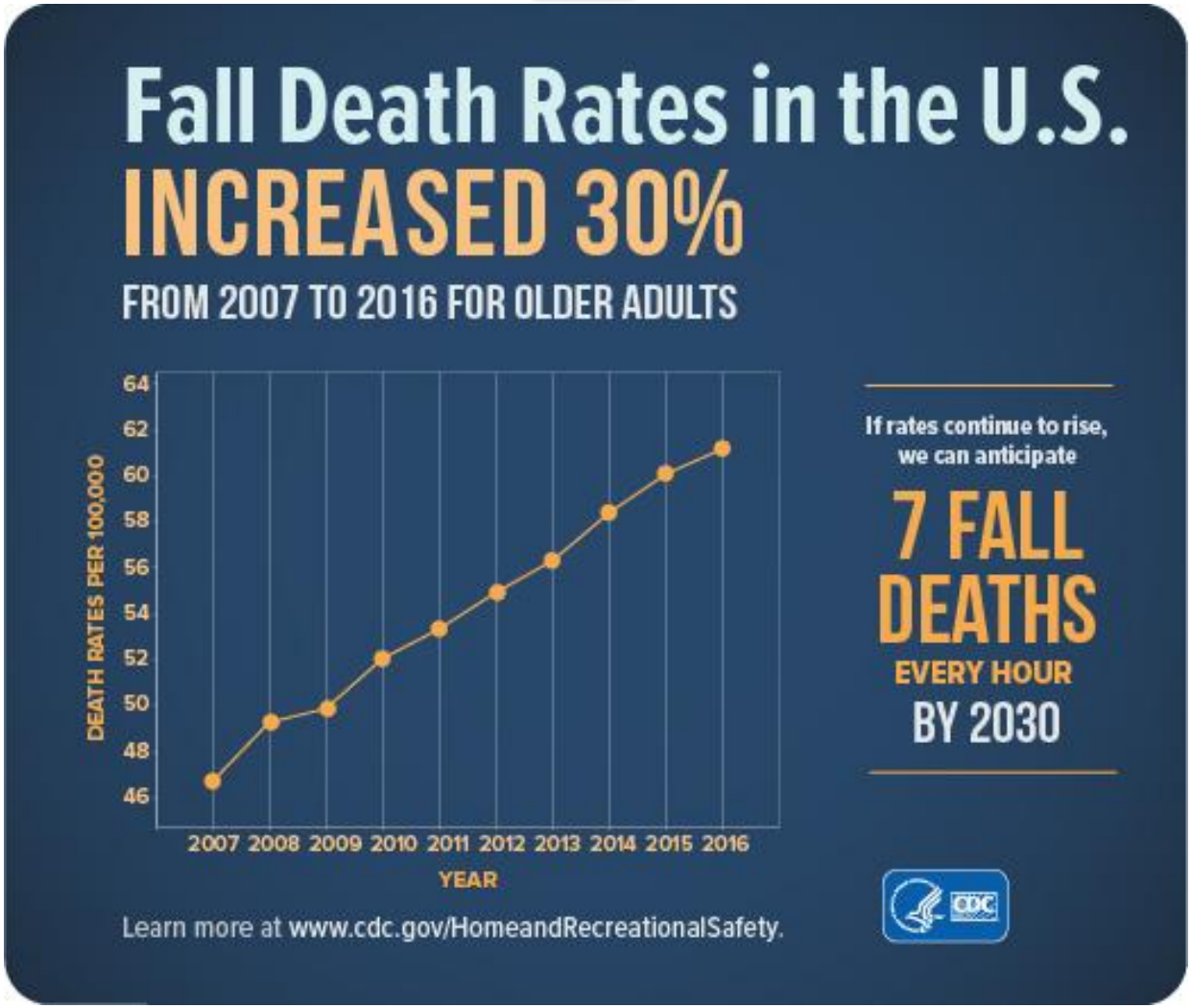


CDC 2017

Screening

Exercise

Falls in the US



In Washington State:

- **1 in 3 older adults falls every year**

- **In 2016:**
  - **19,060 fall-related hospitalizations**
  - **887 fall-related deaths**

In 2017, 34% of all admission to nursing facilities in Washington were for people who had fallen within thirty days prior to admission

Falls Prevention Trivia

TEST YOUR KNOWLEDGE OF RISK FACTORS

Falls Prevention Trivia

Home Safety	Medications	Hidden Fall Risks	Chronic Conditions
Level 1	Level 1	Level 1	Level 1
Level 2	Level 2	Level 2	Level 2
Level 3	Level 3	Level 3	Level 3

End

Home Safety - Level One

A household item that can slip people up

Throw Rug

Home

Home Safety - Level Two

Not having a Handrail increases risk of falls on the stairs

Home

Home Safety - Level Three

Having these in the bathroom can prevent a fall

Grab Bars

Home

Medications – Level One

Having more than four of these will increase risk of falls

Prescription Medications

Home

Medications – Level Two

The risk of a fall is significantly increased when starting or changing medication for

Hypertension

Home

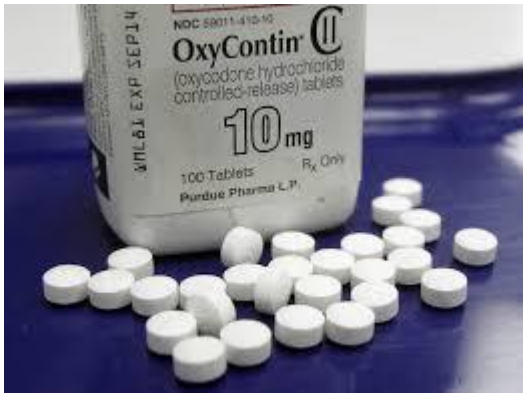
Medications – Level Three

Three types of medications that increase risk for falls

Pain medication

Anxiety medication

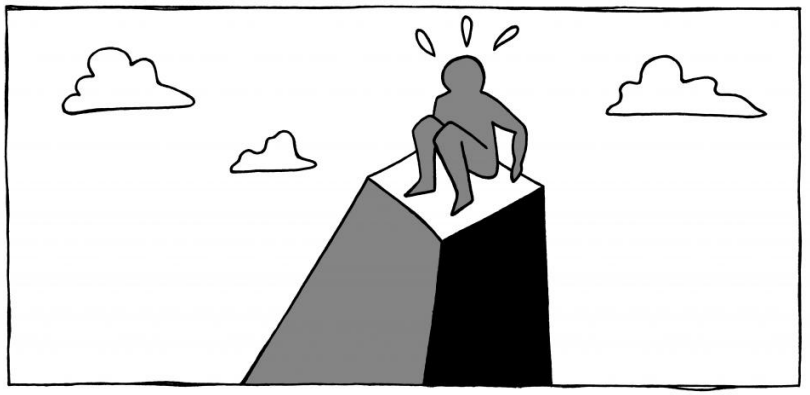
Sleep medication



Home

Hidden Fall Risks – Level One

Fear of Falling causes increased risk of falls



Home

Hidden Fall Risks – Level Two

Can be caused by isolation, lack of appetite or difficulty swallowing

Malnutrition

Home

Hidden Fall Risks – Level Three

Drinking Alcohol increases risk for falls, especially in combination with medications

Home

Chronic Conditions – Level One

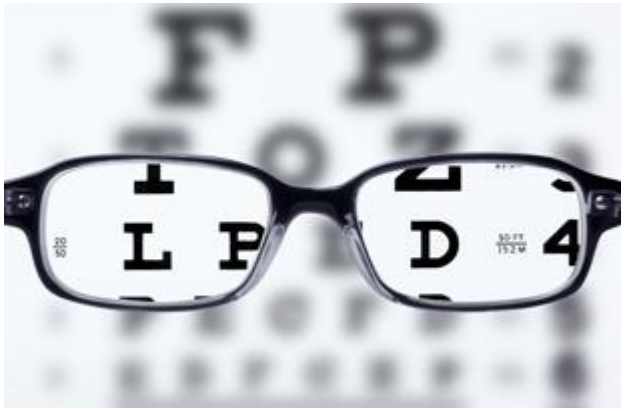
Decreased sensation in this part of the body, often caused by diabetes, increases risk of falls

Feet

Home

Chronic Conditions – Level Two

Older adults should get their _Vision_ checked every year to decrease risk of falls



Home

Chronic Conditions – Level Three

Many memory loss diagnoses fall under this broad category, which significantly increases risk of falls.

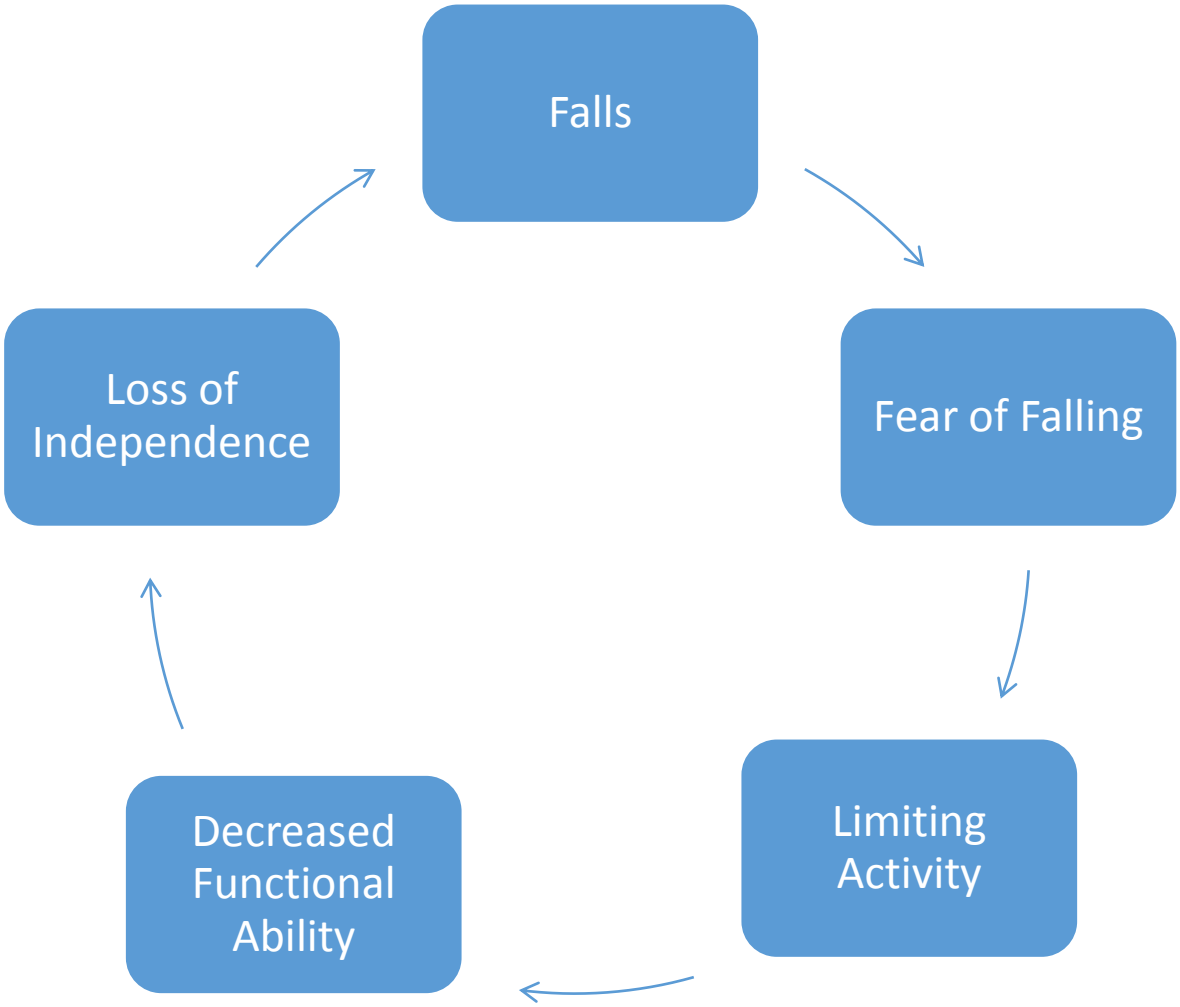
Dementia

Home

Falls Prevention

RISK FACTORS AND SCREENING

Negative Cycle of Falling



High Risk Groups

- Age 85+
- Cognitive Impairment
- Chronic Conditions
- Homebound
- Polypharmacy

Leading Risk Factors For Falls

- Decreased leg strength and balance
- Unsafe home environment
- Polypharmacy and specific medications
- Fear of falling
- Vision and Hearing Problems
- Decreased sensation in feet
- Malnutrition
- Alcohol and Substance Misuse
- Nocturia/Incontinence
- Cognitive Impairment*
- Advanced Age*
- Previous falls, especially with injury*
- Chronic Conditions*

- *Non-Modifiable

Reccomended Screening Tools

- Nursing-Specific:
  - STRATIFY
  - Medication Fall Risk Score
- Generalized:
  - STEADI Self-Assessment
- Functional Assessments– from STEADI Toolkit
  - 30 Second Sit to Stand
  - TUG (Timed Up And Go)
  - Four Stage Balance Test

STRATIFY Risk Assessment Tool

Answer all five questions below and count the number of "Yes" answers.

#	Question	Yes / No	
1	Did ~~the patient present~~ to hospital with a fall or has he or she fallen on the ward since admission (**recent history of fall**)?	Yes = 1	No = 0
2	Is the patient **agitated**?	Yes = 1	No = 0
3	Is the patient **visually impaired** to the extent that everyday function is affected?	Yes = 1	No = 0
4	Is the patient in need of especially **frequent toileting**?	Yes = 1	No = 0
5	Does the patient have a combined **transfer and mobility** score of 3 or 4? (calculate below)	Yes = 1	No = 0
	Transfer score: Choose **one** of the following options which best describes the patient's level of capability when transferring from a bed to a chair: 0 = Unable 1 = Needs major help 2 = Needs minor help 3 = Independent		
	Mobility score: Choose **one** of the following options which best describes the patient's level of mobility: 0 = Immobile 1 = Independent with the aid of a wheelchair 2 = Uses walking aid or help of one person 3 = Independent		
	Combined score (**transfer + mobility**): _____		

Total score from questions 1-5: _____

0 = Low risk
1 = Moderate risk
2 or above = High risk

Medication Fall Risk Score

Medication Fall Risk Score

Point Value (Risk Level)	American Hospital Formulary Service Class	Comments
3 (High)	Analgesics,* antipsychotics, anticonvulsants, benzodiazepines†	Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition
2 (Medium)	Antihypertensives, cardiac drugs, antiarrhythmics, antidepressants	Induced orthostasis, impaired cerebral perfusion, poor health status
1 (Low)	Diuretics	Increased ambulation, induced orthostasis
Score ≥ 6		**Higher risk for fall; evaluate patient**

* Includes opiates.
† Although not included in the original scoring system, the falls toolkit team recommends that you include non-benzodiazepine sedative-hypnotic drugs (e.g., zolpidem) in this category.

STEADI Self Assessment Tool

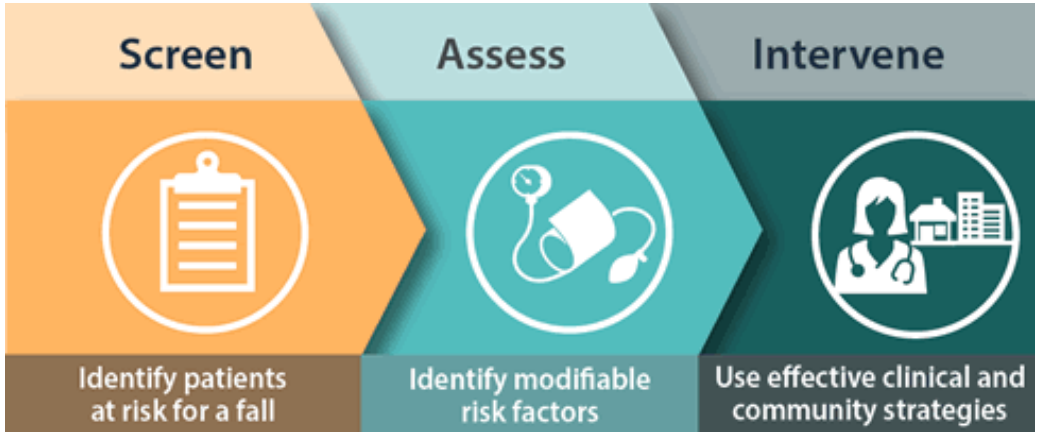
Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

CDC STEADI Tool

- *Created in collaboration with University of Washington*



STEADI Stopping Elderly Accidents, Deaths & Injuries

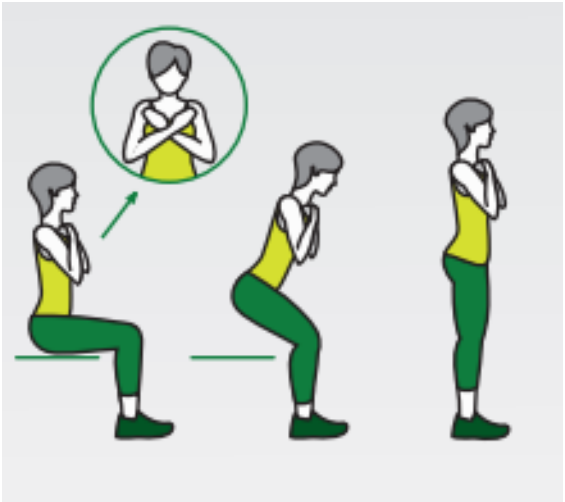
30 Second Chair Stand Test - Practice

1. Explain the directions
   A. Sit in the middle of the chair
   B. Do not use your hands to push
   C. When I say "go", stand up and sit down as many times as you can in 30 seconds
   D. Stand up all the way each time, and sit safely

2. Prepare your stopwatch/timer

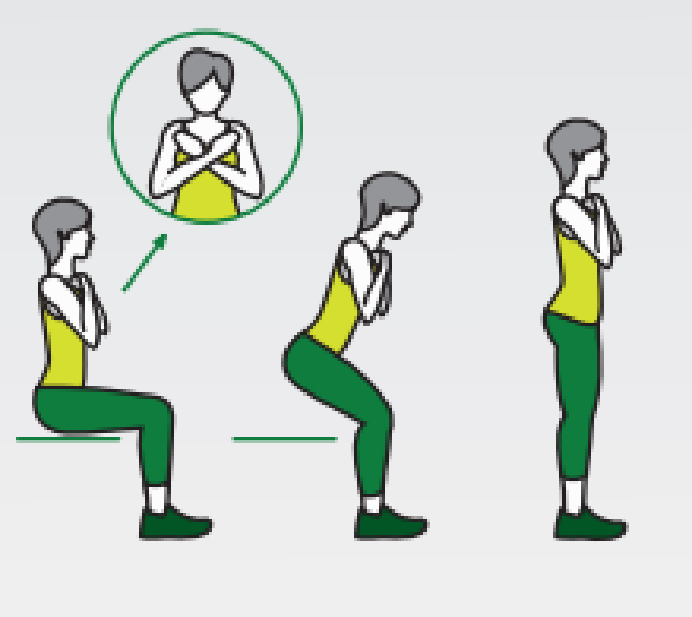
3. Time the test

4. Record the score
   - Using normative values



30 Second Chair Stand Test - Scoring

- Normative Values:



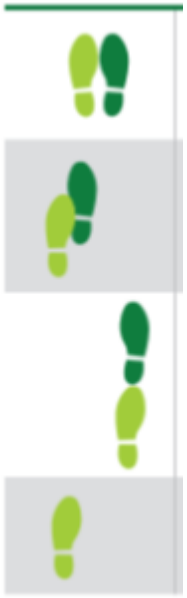
SCORING

Chair Stand
Below Average Scores

AGE	MEN	WOMEN
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4

A below average score indicates a risk for falls.

Four Stage Balance Test



1. Explain the test
   A. Four testing positions
   B. Can have help to get into position
   C. Must hold position on their own
      - Cannot use assistive device

2. Time each position for ten seconds
   - If patient holds the position for ten seconds, move to the next position

3. Stop test when patient <u>cannot</u> hold a position for full 10 seconds
4. Record the last position they completed successfully

Four Stage Balance Test - Practice

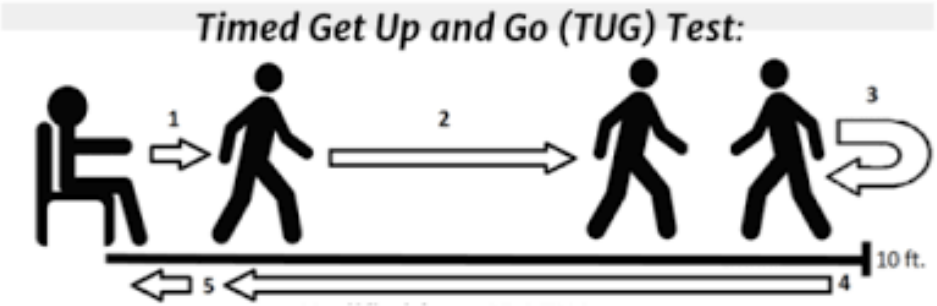
	① **Stand with your feet side-by-side.**	Time: _____seconds
	② **Place the instep of one foot so it is touching the big toe of the other foot.**	Time: _____seconds
	③ **Tandem stand: Place one foot in front of the other, heel touching toe.**	Time: _____seconds
	④ **Stand on one foot.**	Time: _____seconds

Timed Up and Go (TUG) Test - Practice

1. Explain the test
   A. When I say go, you will
      - Stand up, walk to the line, turn and walk back
      - Can use arms to push up if needed
      - Can use assistive devices if needed

2. Time the test
   1. Timer starts when you say go
   2. Timer stops when the patient sits down

3. Score the test



Timed Up and Go (TUG) Test - Scoring

① Instruct the patient:

NOTE: Always stay by the patient for safety.

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

Modifying Risk Factors For Falls

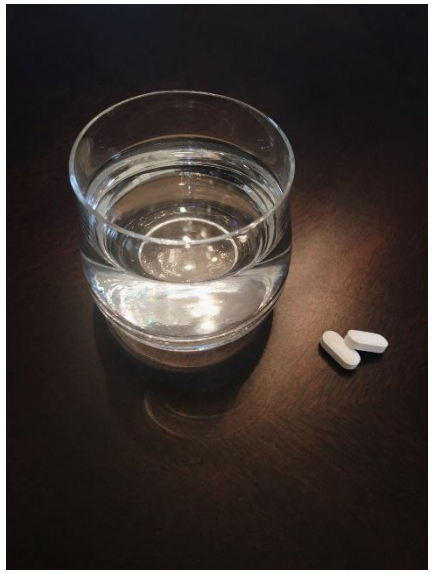
Risk Factor	Intervention	Low Barrier
Difficulty walking or standing, uses arms to stand	PT, Evidence Based Programs	STEADI Sit to Stand Exercise
Fear of Falling	Evidence Based Programs	Caregiver Falls Prevention Conversation Guide (NCOA)
Unsafe Home Environment	OT, Home modification	DOH Resource Guides
4 or more medications	Have MD review Meds, change as needed	Use Medication Risk Fact Sheet from STEADI
Vision, Sensation, Hearing, Nocturia, Dizziness	Specialist Appointments	Safety modifications

Falls Prevention

MODIFYING RISK FACTORS

Medications

- Medications with increased risk of falls:
  - Benzodiazepines (Anxiety medications)
  - Tranquilizers (sleep medications)
  - Antidepressants
  - Diuretics
  - Opioid pain medication



- All anti-hypertensives are associated with increased fall risk in older adults three weeks after new or changes dosages, especially in those who have fallen previously
  - Citations: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4136657/
  - https://www.ncbi.nlm.nih.gov/pubmed/20650874

SAFE Medication Review Framework

FACT SHEET

SAFE

Medication Review Framework

Use this framework to conduct a medication review to help prevent older adult falls.

Link to resource on CDC website

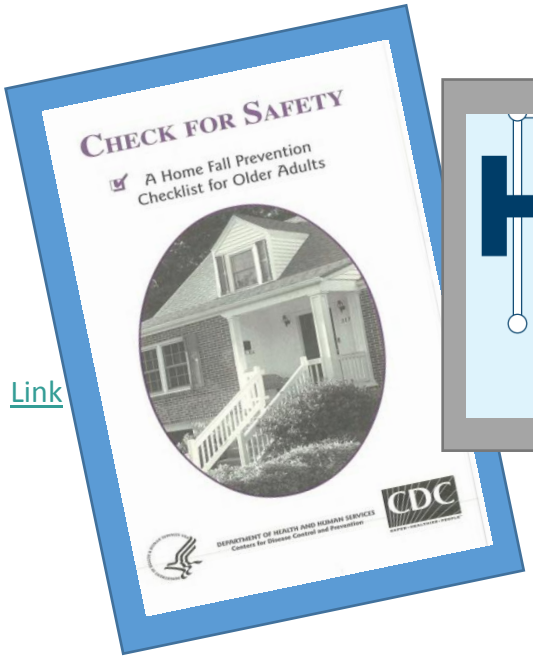
STEADI Stopping Elderly Accidents, Deaths & Injuries

A Team-based Approach

Adapted from existing medication therapy management tools developed and used by pharmacists, this review framework uses the **SAFE** process: **Screen, Assess, Formulate,** and **Educate.**

Home Safety

- Printed Resources from DOH and AARP
- Local Resources
  - Rebuilding Together
  - EMS Programs



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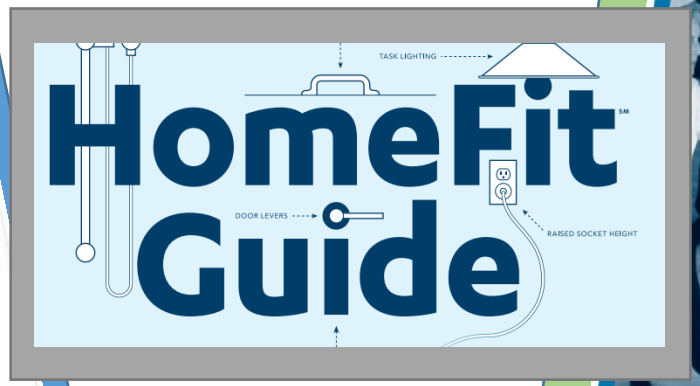

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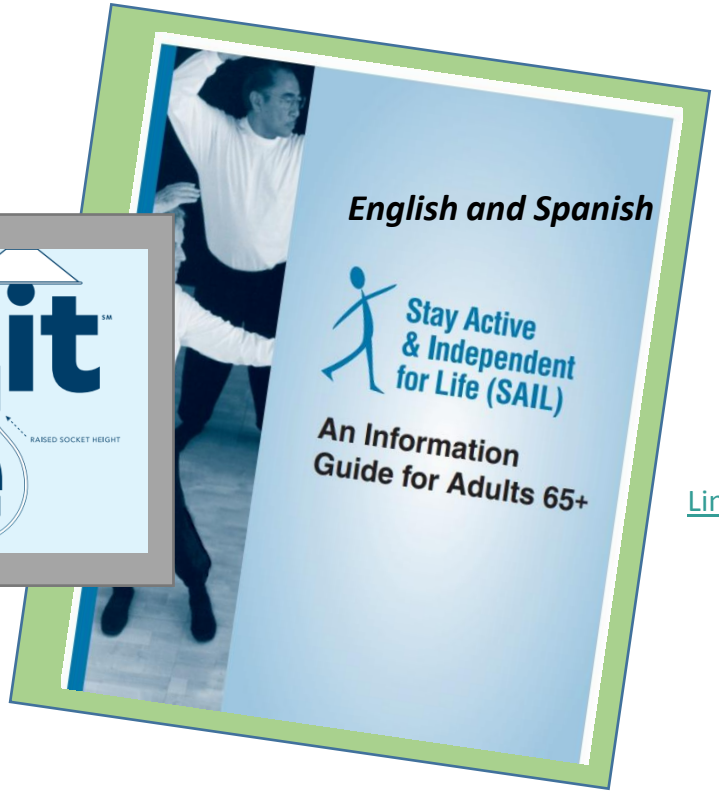


Link

Common Home Safety Issues in Community Settings

- Inadequate/absent grab rails in bathroom
  - Next to shower
  - Next to toilet (may also need raised toilet seat)
  - At correct height for client to use (UE ROM, height)

- Assistive device height or malfunction
  - Should be at wrist or hip (greater trochanter)
  - 4WW brakes loose (DME retailer or PT)
  - Wrong AD, using on wrong side

- Bed transfer set up unsafe
  - Bed too high/no crash mat available
  - AD not close enough to bed

Evidence Based Community Falls Prevention Programs

- Available in the community at low or no cost
- Educational Programs and Exercise Classes
- Listed on Washington Tracking Network:
  - https://fortress.wa.gov/doh/wtn/WTNPortal/#!q0=464

Stay Active & Independent for Life (SAIL)

a strength, balance, and fitness class for adults 65+

Link

tai ji quan

Moving for Better Balance®

Link

Fall Scape

Link

ENHANCE

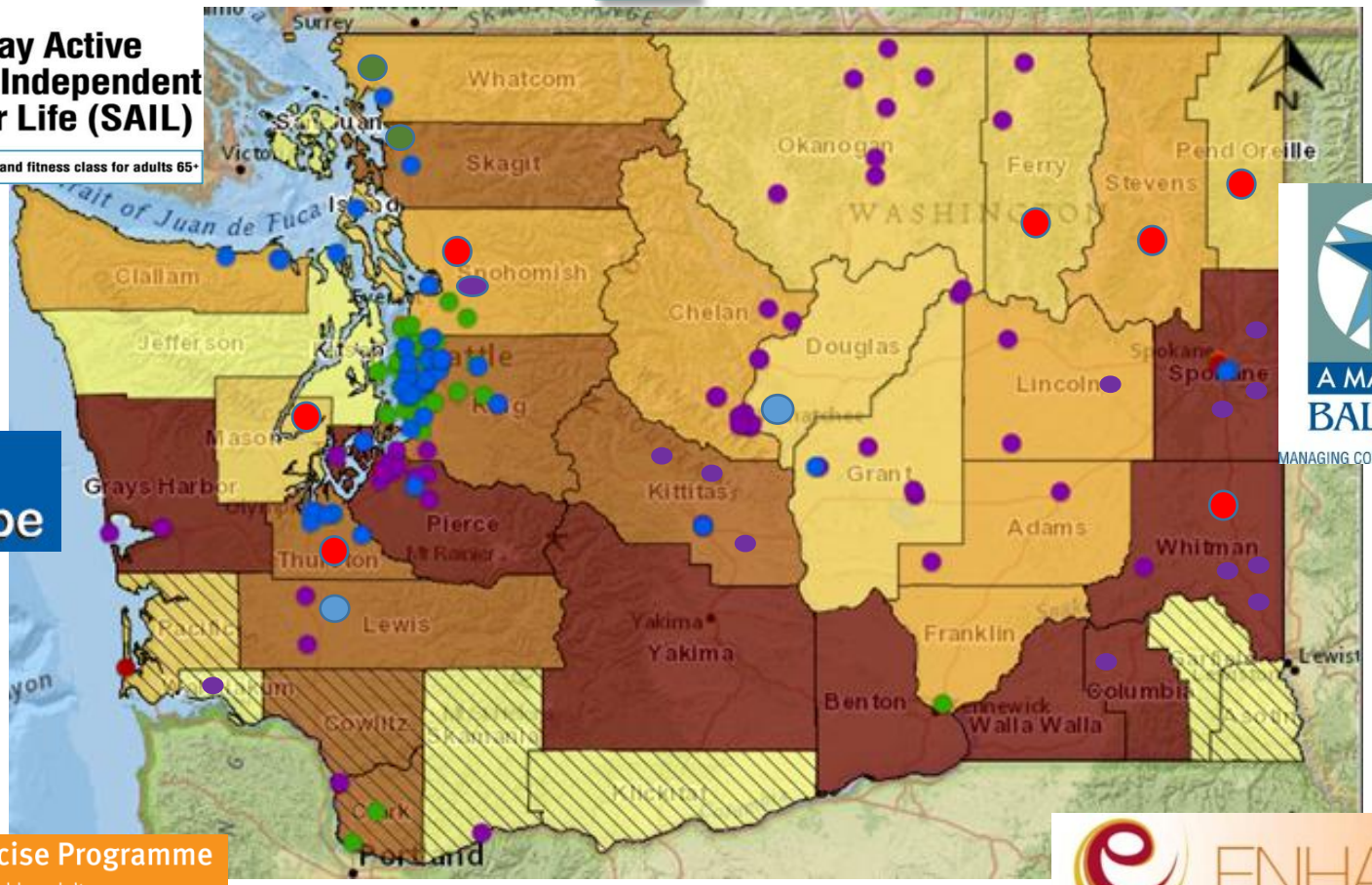
Link

A MATTER OF BALANCE

MANAGING CONCERNS ABOUT FALLS

Link

WA Evidence Based Community Falls Prevention Programs



Stay Active & Independent for Life (SAIL)

a strength, balance, and fitness class for adults 65+

Fall Scape

A MATTER OF BALANCE

MANAGING CONCERNS ABOUT FALLS

Otago Exercise Programme

to prevent falls in older adults

ENHANCE

tai ji quan Moving for Better Balance®

How To Get Up From A Fall

Source: "I Have Fallen and I CAN Get Up" Providence Health and Services 2017

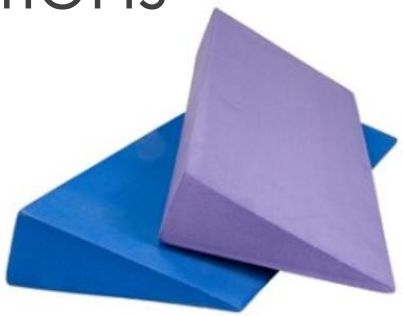
1)Roll over onto your side

2)Get into quadruped

3)Use couch to push up with hands

4)Turn and sit on couch

Falls Prevention Considerations for Bedbound Clients



Non-Restraint Tools*

Cushion wedges

Transfer Poles

Lifeline Pendant

Care plan 2-person rolling, or place bed next to wall for rolling

Crash mat

Case Study: Mr. Jones

Mr. Jones is a pleasantly confused and occasionally agitated 75-year-old man, who lives in an Adult Family Home where he has assistance with all IADLs, and 24/7 supervision. He can dress and feed himself and ambulates with a 4WW that his sister gave him. He has had three non-injury falls in the past week, two were in bathroom, and the third was next to his bed. Mr. Jones states that he fell because he "lost his bearings" and that he was "trying to go too fast."

He indicates on the STEADI self-assessment that he rushes to the bathroom and his medications sometimes makes him light-headed, and his STS score indicates he has a high risk of falling. Medication list includes 80mg of Lasix 2x/day, increased recently from 40mg by his cardiologist. The AFH bathroom has one grab rail next to the shower and several fluffy bath rugs.

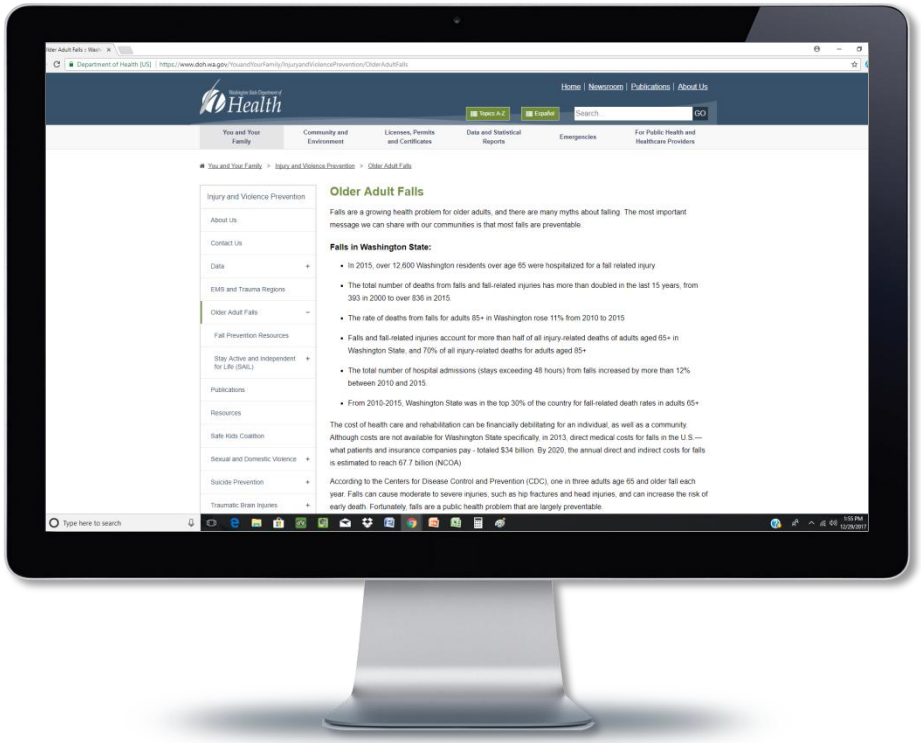
The AFH caregiver states that Mr. Jones has been getting up suddenly which doesn't give staff enough time to get there and help him before he falls. She wants to know – what can you do to help him stop falling?

Questions?

https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/OlderAdultFalls

Website

- -Resources
- -Links
- -Data
- -News

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