Live. Learn. Hope.

Fall Risk Assessment

Clinical Education
4/2021

Learning Objectives

At the end of the presentation, the nurse will be able to:

1. Explain the definitions of falls.
2. Lists the common modifiable & non-modifiable fall risk factors.
3. Identify the measures NKC uses to raise awareness in preventing falls.
4. Identify when fall risk assessment should be completed.
5. Understand the steps in completing fall risk assessments & meaning of scores.
6. Describe the nursing implications when a patient falls – with or without injury.

Fall - Definitions

- FALL – An unexpected, inadvertent change in position that causes a person to land at a lower level; on an object, or the floor/ground

(Note: A fall doesn't always involve landing on the floor)

- ASSISTED FALLS – When a caregiver assists the patient to the floor from chair, bed, wheelchair, or toilet, etc.

(Note: An assisted fall is still treated as a fall)

- FOUND DOWN – Anytime a patient is found on the floor, it is assumed the patient has fallen and treated as such

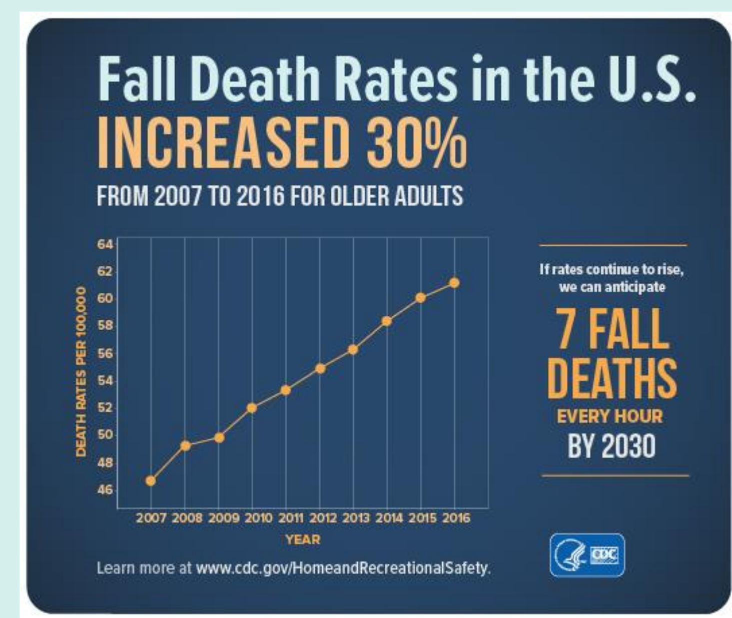
- WITNESSED or NOT WITNESSED

Impact of Falls – U.S.

- Falls are the number one cause of "unintentional injury" and the & 7th leading cause of death of death among older adults in the U.S.
- Each year, 3 million older adults are treated in ED for fall injuries
- Over 950K people hospitalized every year due to fall injury that resulted in head injury or hip fracture
- Falls are the most common cause of traumatic brain injuries

Impact of Falls – U.S.

- About 1 out of 3 adults > 65 years old in the U.S. fall each year and 1 out of 5 of those result in serious physical injury
- Approximately 32,000 Americans die each year due to falls – increased of 30% in older adults from 2007 - 2016
- In 2015, the total medical costs for falls totaled more than $50 billion



Impact of Falls - NKC

In calendar year 2020, there were 143 recorded incidences of patient falls at NKC facilities

Falls Report by Specific Event Type

For Last Month

(Event Date is within 01-01-2020 and 12-31-2020) and ((General Event Type is equal to "Fall") and ((File State is equal to "New") or (File State is equal to "In-Progress") or (File State is equal to "Closed"))) and (((Scope is equal to "All")))

Number of Events

0
5
10
15
20
25
30
35

36
29
17
15
14
13
6
4
4
3
1
1

While Ambulating
Outside on Grounds of Facility
From Toilet/In Bathroom
While Weighing at the Scale
Unknown/Found on Floor
From Chair
From Wheelchair
Fall at Home
While Transferring
Other (please specify)
From Bed
From Equipment

Type of Fall

Consequences of Falls

Consequences of Falls

- Head Injury
- Spine Injury
- Hip Injury
- Soft Tissue Injuries
- Fractures
- Laceration s
- Fear of Falling
- Functional Decline
- Decreased Activity

Risk Factors

Non-modifiable Risk Factors:

- Age > 65 years old, higher risk > 85 years old
- Gender – women have higher risk / incidence of falls
- Race/Ethnicity – Native American & Alaskan Native
- History of falls

Modifiable Risk Factors:

- Difficulties with gait and balance
- Lower extremity weakness
- Adverse drug events and polypharmacy
- Vitamin D deficiency
- Orthostatic hypotension
- Visual impairment
- Foot issues or improper footwear
- Environmental hazards

Risk Factors

Common Health Conditions:

- Neurological conditions including stroke, Parkinson’s disease, and dementia
- Depression
- Musculoskeletal conditions, such as arthritis
- Cardiac conditions, such as arrhythmia
- Diabetes
- Urinary incontinence

Common Causes of Falls

There are numerous reasons why people fall. Some of the most common causes of falls on our older CKD patients are due to:

- Multiple comorbidities
- Postural instability
- Decreased muscle strength
- Unsteady gait
- Visual or cognitive impairment
- Polypharmacy
- Metabolic imbalance
- Environmental factors

Falls are Preventable

Falls are *Preventable*

Remember:

Approximately half of older adults who fall do not tell their healthcare providers about it or discuss their concerns for falling. Therefore, routinely ask the question "*have you fallen in the past….*"

Many falls can be prevented by addressing the modifiable risk factors such as unsteady gait and balance, orthostatic pressures, & environmental factors.

Fall Prevention at NKC

- NKC has developed a comprehensive fall prevention program
- NKC's fall prevention program targets specific patient problems with individual care strategies
- Includes patient and staff education regarding fall risks and fall prevention
- Fall Prevention Awareness Campaign

Program Purpose

NKC's Fall Reduction/Prevention Program aims to:

1. Promote commitment to patient safety.
2. Provide a multidisciplinary information sharing approach for risk assessment, root cause analysis, and management strategies for fall prevention tools.
3. Integrate the latest clinical guidelines from community partners and agencies in preventing falls.
4. Ensure a comprehensive documentation process using the available internal tools and resources along with continuous process evaluation on effectiveness of interventions based on outcomes.

Fall Prevention Awareness - NKC

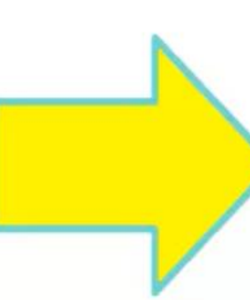
Goals of Fall Prevention Campaign

- Improve Patient Safety
- Decrease the Number of ED Visits & Hospitalizations
- Increase Communication between the Patient and Interdisciplinary Team
- Recognize Common Causes of Falls
- Implement Meaningful and Appropriate Interventions

Fall Prevention Safety Bundle

Patients

Fall Prevention *Safety Bundle*



Preventing Falls at Home

Many falls are preventable—create a safe living space with these tips!

Prepare your home for safety

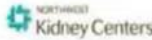
- Add handrails in stairwells and hallways; limit trips up and down if unsteady
- Place grab bars next to the toilet and inside tub or shower; use nonslip mats on slick surfaces
- Use a raised toilet seat to help you sit and stand, a shower bench, and handheld shower head
- Keep things you use often within easy reach or use a reach stick; never use a step stool or chair
- Use chairs with solid armrests; avoid chairs with wheels that can slip away from you
- Carry a phone or alert system with you at all times to use if you fall and need help
- Ask your doctor for a *Fall Risk Assessment* for occupational therapy to check your home's safety

Watch your step

- Pick up objects you could trip over—small furniture, cords, items on floor
- Watch out for pets when standing or walking
- Remove throw rugs or secure edges to the floor with double-sided tape
- Wear shoes or slippers with non-skid soles; avoid loose clothing that may drag on ground
- Take it slow when changing from sit to stand position and vice versa to avoid light-headedness
- Use a cane, walking stick, walker, or mobility aide to keep you balanced
- Exercise regularly to keep muscles stronger and joints more flexible
- Learn if your medications may make you feel sleepy or dizzy; limit alcohol or drug use that can impair balance

Light it right

- Install bright light bulbs throughout your home, such as in stairways and hallways
- Add night-lights in all bedrooms and bathrooms for better sight at night
- Keep a flashlight next to the bed for emergencies



Fall Prevention Awareness - Patients

Fall Prevention literatures provided to patients

- *Preventing Falls at home*
  - Focuses on balanced exercise program, regular MD check up, medication awareness (doses, side effects, etc.), vision & hearing check ups, home safety, & talking to family.

- *Preventing Falls in the clinic*
  - Focuses on effects of dialysis, prevention of dizziness, avoiding quick position changes, environmental awareness, & effects of medications

Fall Prevention Safety Bundle

Staff

Fall Prevention *Safety Bundle*

- Relias Education:
  1. Intro to Fall Prevention Bundle
  2. Transfers & Lifting
- New YELLOW wipeable gait belts
- Post Fall Huddle (at huddle board):
  Team huddles within 3 days of fall, include patient, family' & care team
- Indicate high fall risk patients on the schedule.
- Place Yellow Sticker on the saline bag of high fall risk patients

Fall Prevention Awareness - Staff

Fall Prevention Awareness Campaign

- Mandatory staff training
- Posters, buttons, staff memo, & emails

Policies & Procedures

- Fall Reduction / Prevention Program – *QI-F17502*
- Fall SAS Patient Fall Disposition Pathway – *QI-Q17500C*
- Fall Risk Assessment – *QI-Q17500A-C*
- Person “Found Down” – Patient or Visitor – *ADM-P12016*

Nurse Specific Roles

Completion of Fall Risk Assessment

- All NKC patients will have a **Fall Risk Assessment** completed within 30 days of admission

- All NKC patients will have an updated **Fall Risk Assessment** done with each Plan of Care (POC)

- All NKC patients involved in a fall will have an updated **Fall Risk Assessment** completed at the time of the incident

Risk Assessment Workflow

Completing the Fall Risk Assessment involves several steps:

1. Patient Assessment
   - Mental status, **recent & history of falls, elimination & vision status, gait & balance
2. Medication Reconciliation **
   - have patient bring ALL medications including vitamins – "brown bag" method
3. Review of patient records
   - BP changes in RTC, comorbid conditions (from H&P, hospital discharge summary, MD notes, etc.)
4. Enter the score in the EMR

Where to Find Info in EMR

Prior to completing Fall Risk Assessment, go to Clarity > Patient > **Patient Chart View**

Provides easy access to patient's:

- Medications
- Treatment History
- Hospitalization
- Notes
- Document Management – scanned hospitalization notes

History of Falls

Nurses need to fully investigate patient's fall history by asking these questions:

- Have you had any falls or slips in the past 6 months?
- When & where did you fall?
- Did you hurt yourself and what type of injury occurred?
- What symptoms did you feel before the fall?
- What do you think contributed to your fall?

Fall Risk Assessment Form

Parameter		Score	Status / Condition	Score
A.	Mental Status	0	Alert (oriented X 3)	
		2	Disoriented X3 at all times	
		4	Intermittent confusion	
B.	History of Falls (Past 6 months)	0	No previous falls last 6 months (If needed refer to progress notes for falls at home.)	
		2	Falls reported at home past 6 months	
		4	Fall at NKC past 6 months. (Check NKC Fall Report)	
C.	Elimination Status at Unit	0	Continent	
		2	Occasionally Incontinent (ambulatory)	
		4	Incontinent (ambulatory)	
D.	Vision Status (Staff Assessment of vision)	0	Adequate (with or without glasses) (can see to ambulate)	
		2	Poor (with or without glasses) (cannot see well to ambulate)	
		4	Legally blind (cannot see objects ahead of them)	
E.	Gait / Balance	0	Gait / Balance normal	
		1	Balance Problem while standing/walking	
		1	Decreased muscular coordination	
		1	Requires use of assistive device (walkers, cane)	
		2	Needs assistance of person	

F.	Systolic Blood Pressure	0	No noted consistent drop between Sitting / Standing (less than 10mm).	
		2	Consistent drop less than 20mm between (circle one) Sitting / Standing Lying/Sitting Pre-sitting / Post sitting (for wheel chair bound) ______________________________.	
		4	Consistent drop more than 20mm between Sitting/ Standing Lying / Sitting Pre-sitting / Post sitting (for wheel chair bound) ______________________________.	

G.	Medications Note: Reference list on reverse side of this form	Respond based on types of medications: Anesthetics, Antihistamines, Antiseizures, Antihypertensives, Benzodiazepines, Cathartics, Diuretics, Sedatives/Hypnotics, Hypoglycemics, Narcotics, Psychotropics.		
		0	None of these medications.	
		2	Has taken 1-2 of these medications in last 7 days.	
		4	Takes 3 or more of these medications currently.	
H.	Predisposing Diseases	Respond based on predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's disease, Loss of limbs, Seizures, Arthritis, Osteoporosis, Hx of fractures, Neuropathy.		
		0	None present	
		2	1-2 present	
		4	3 or more present	
Fall is: ☐ pre ☐ intra ☐ post dialysis			Total Score:	

RN/LPN:____

Patient's Name: ______________________________ ______________________

Medications

The side effects of these medications increases the risk of falls.

ANTI-HYPERTENSIVES	ANTIDEPRESSANTS
Beta Adrenergic Receptor Antagonists (Beta Blockers)	Tricyclics
Metoprolol (Lopressor®, Toprol®)	Amitriptyline
Atenolol (Tenormin®)	Nortriptyline (Pamelor®)
Propranolol (Inderal®)	Doxepin (Sinequan®)
Mixed Alpha-Beta Adrenergic Receptor Antagonist	**Selective Serotonin Reuptake Inhibitors (SSRI's)**
Labetalol (Normodyne®, Trandate®)	Fluoxetine (Prozac®)
Carvedilol (Coreg®)	Sertraline (Zoloft®)
	Paroxetine (Paxil®)
Alpha Adrenergic Receptor Antagonists (Alpha Blockers)	Citalopram (Celexa®)
Doxazosin (Cardura®)	Escitalopram (Lexapro®)
Terazosin (Hytrin®)	MISCELLANEOUS
Tamsulosin (Flomax®)	Venlafaxine (Effexor®)
Prazosin (Minipress®)	Duloxetine (Cymbalta®)
Alpha Agonist, Centrally acting	Buproprion (Wellbutrin®)
Clonidine (Catapress®)	Nefazodone (Serzone®)
Calcium Channel Blockers	Mirtazapine (Remeron®)
Amlodipine (Norvasc®)	Trazodone (Desyrel®)
Nifedipine (Procardia®, Adalatt®)	***SEDATIVES/HYPTONICS/ANXIOLYTICS***
Diltiazem (Cardizem®)	Benzodiazepines
Felodipine (Plendil®)	Lorazepam (Ativan®)
Isradipine (Dynacirc®)	Alprazolam (Xanax®)
Verapamil (Cala n®, Verelan®, Isoptin®)	Diazepam (Valium®)
	Clonazepam (Klonopin®)
Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors)	Temazepam (Restoril®)
Lisinopril (Prinivil®, Zestril®)	Triazolam (Halcion®)
Enalapril (Vasotec®)	MISCELLANEOUS
Benazepril (Lotensin®)	Zolpidem (Ambien®)
Quinapril (Accupril®)	Zaleplon (Sonata®)
Ramipril (Altace®)	Buspirone (Buspar®)
Captopril (Capoten®)	PAIN MEDICATIONS
Fosinopril (Monopril®)	Opiates and Opiate Combinations
Angiotensin II Recepetor Antagonists (ARB's)	Oxycodone/Acetaminophen (Percocet®, Tylox®,
Losartan (Cozzar®)	Lortab®, Endocet®, others)
Valsartan (Diovan®)	Hydrocodone/Acetaminophen (Vicodin®,
Irbesartan (Avapro®)	Lorcet®, Anexsia®, others)
Candesartan (Atacand®)	Codeine/Acetaminophen (Tylenol #3®)
Olmesartan (Benicar®)	Propoxyphene/Acetaminophen (Darvocet®)
	Oxycodone (Roxicodone®, Oxycontin®)
Vasodilators	Hydromorphone (Dilaudid®)
Nitrates	Methadone (Dolophine®)
Isosorbide Dinitrate (Isordil®)	Morphine (MS Contin®, Oramorph®, others)
Isosorbide Mononitrate (Imdur®)	Tramadol (Ultram®)
Nitroglycerin	
Peripheral Vasodilators	Non-opiate medications used for pain
Minoxidil (Loniten®)	Tricyclic antidepressants (see above)
Hydralazine (Apresoline®)	Gabapentin (Neurontin®)
ANTITEMETICS	ANTIHISTAMINES
Prochlorperazine (Compazine®)	Hydoxyzine (Vistaril®, Atarax®)
Promethazine (Phenergan®)	Diphenhydramine (Benadryl®)
Metoclopramide (Reglan®)	

The Patient's Score

Parameter		Score	Status / Condition	Score
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		2	Disoriented X3 at all times	
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		4	Fall at NKC past 6 months. (Check NKC Fall Report)	
C.	Elimination Status at Unit	0	Continent	
		2	Occasionally Incontinent (ambulatory)	
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D.	Vision Status (Staff Assessment of vision)	0	Adequate (with or without glasses) (can see to ambulate)	
		2	Poor (with or without glasses) (cannot see well to ambulate)	
		4	Legally blind (cannot see objects ahead of them)	
E.	Gait / Balance	0	Gait / Balance normal	
		1	Balance Problem while standing/walking	
		1	Decreased muscular coordination	
		1	Requires use of assistive device (walkers, cane)	
		2	Needs assistance of person	
F.	Systolic Blood Pressure	0	No noted consistent drop between Sitting / Standing (less than 10mm).	
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		0	None of these medications.	
		2	Has taken 1-2 of these medications in last 7 days.	
		4	Takes 3 or more of these medications currently.	
H.	Predisposing Diseases		Respond based on predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's disease, Loss of limbs, Seizures, Arthritis, Osteoporosis, Hx of fractures, Neuropathy.	
		0	None present	
		2	1-2 present	
		4	3 or more present	
Fall is: ☐ pre ☐ intra ☐ post dialysis			Total Score:	

EMR Entries

To complete a **Fall Risk Assessment** in Clarity > **Patient** > **Patient Assessments** then select:

Annual Fall Assessment (for initial, POC, & post fall updates)

Post Fall Assessment – after fall incident in addition to updated Annual Fall Assessment

The patient's Fall Assessment score will appear in the **RTC** > **Pretreatment** screen

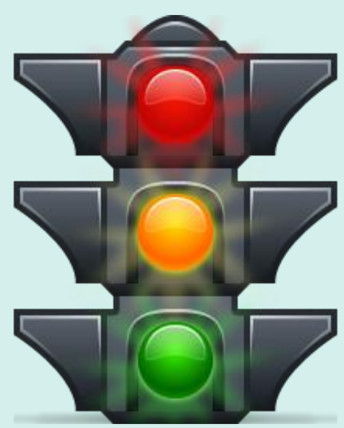
Final Fall Score (from Annual Fall Assessment)	**02/11/2020** 6

Refer to Clarity User Guide in K-NET

Fall Risk Categories

The fall risk assessment **score** identifies the patient’s risk level as follows:

Score Range	Risk Level	Color Coding
0 - 6	LOW	GREEN
7 -11	MODERATE	YELLOW
12 or higher	**HIGH**	**RED**



Interventions – Low Risk

GREEN PRECAUTIONS (score = 0 – 6)

Green precautions are for all NKC patients

- ✓ Chair/bed wheels locked
- ✓ Dialysis space free of clutter/spills
- ✓ Personal items within reach
- ✓ Adequate lighting
- ✓ Pt oriented to unit, call light, and fall prevention program
- ✓ Pt educated on fall prevention
- ✓ Pt instructed to ask for assistance when needed

Interventions – Moderate Risk

YELLOW PRECAUTIONS (score = 7 – 11)

Yellow precautions = all green interventions plus the following:

- ✓ Weights with staff standby/assist
- ✓ Standby/assist with transfers and ambulation prn
- ✓ Remain outside of bathroom door when patient in bathroom
- ✓ Social Worker evaluation for medical equipment prn
- ✓ Fall risk addressed in POC

Interventions – High Risk

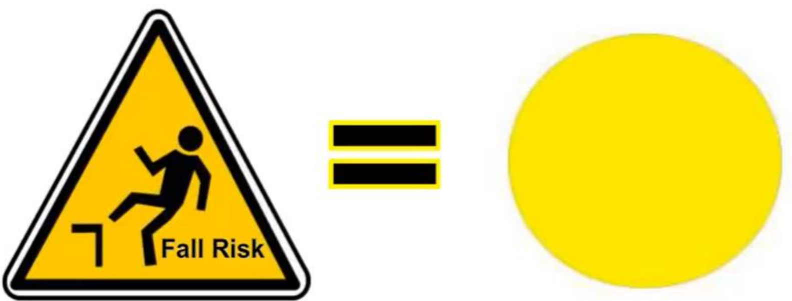
RED PRECAUTIONS (score = 12 or higher)

RED precautions = all green & yellow interventions plus the following:

- ✓ Assist with all transfers
- ✓ Consistent use of available assistive devices
- ✓ BP per protocol without exception
- ✓ Escort everywhere in unit (lobby, scale, chair, bathroom)
- ✓ Assure assistance to and from transportation

High Risk - Awareness

The YELLOW sticker on Saline bags provides quick visual reminder & identifies high fall risk patients



Our Dialysis Environment

Safety and Fall Prevention

Ensure the patient station is free of clutter, and all cords are behind the chair.

Clean up spills and slick areas promptly.
Use wet floor signs!

To prevent falls, walk and assist patients to and from waiting room, scale, and chair.

Recognize changes in a patient's mobility and report to your Primary Care RN.

Assist patients with their belongings as needed.

Position your computer on wheels out of the flow of traffic.

Response To Patient Fall

Nurse completes patient assessment:

- ✓ Check for injuries
- ✓ Assess level of consciousness
- ✓ Determine if safe to move patient

(Note: If not safe to move patient or unable to move patient, call 911)

- If unwitnessed fall, attempt to determine how fall occurred

Patient Fell - Next Steps

If safe to move the patient:

- Move patient into dialysis unit
- Nurse might need to examine patient more thoroughly for injuries
- Assign staff member to monitor the patient
- Contact patient's MD
- Contact patient's family / caregiver

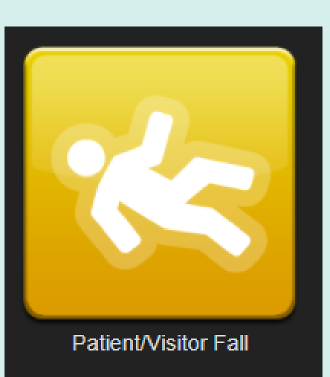
Determine Patient Disposition

When contacting patient's MD, determine:

- Does patient need to be sent to the ER?
- Did the fall occur pre-dialysis? If so, is it safe to dialyze patient? Should heparin dose be decreased or held?
- Did the fall occur post-dialysis? Can patient be sent home? Will caregiver be available to monitor patient?
- Use **SBAR** charting

For Injured Patient

- ✓ Notify MD and send patient to ER
- ✓ Contact patient's family
- ✓ If unit manager unavailable, notify NKC Administration

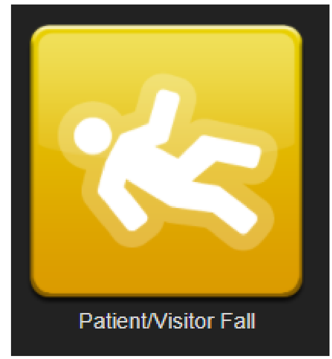


Follow Up & Documentation

- ✓ Document in EMR and complete SAS report
- ✓ Include assessment, communication with MD, patient disposition, instructions given to patient / caregiver
- ✓ Contact patient/caregiver within 48 hours to check patient’s condition and document in EMR
- ✓ If patient fell at home, document in EMR and complete an SAS report
- ✓ Complete an updated Fall Risk Assessment Form!

Fall Disposition Pathway

NKC Fall Disposition Pathway QI-Q17500C – provides an algorithm guide for nurses to follow in an event of patient fall.



NORTHWEST Kidney Centers

PATIENT FALL

ASSESS THE PATIENT

Injury Requiring Medics (911)

Immediate Interventions as Needed- Stay with the Patient

Patient Transported to the Hospital

- YES → Notify Nephrologist and Community Care Facility
- NO → Call Nephrologist to determine next steps. Get Heparin Directives

Notify Manager/ Supervisor

Minor/No Injury Noted Upon Assessment

Call MD to inquire about Post Fall Heparization

Initiate Dialysis

Continue to Assess Patient throughout treatment for latent signs/symptoms

Notify Supervisor, Family and Community Care Facility of event

Instruct Family to watch for pain, signs of bleeding or other unusual symptoms

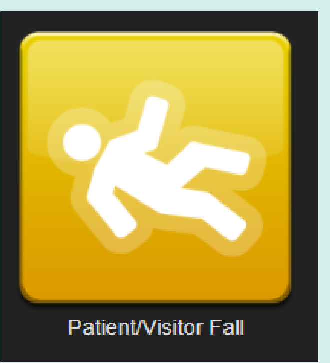
- Document the event, communication & outcome in the EMR
- Complete a Post Fall Huddle
- Complete a Post Fall Assessment
- Complete an SAS

Person Found Down Outside of Unit

- ✓ Call 911
- ✓ Request assistance from the unit

(Note: A nurse may attend to person IF safe to leave the unit. A nurse may NOT leave unit if he/she is the only nurse. A nurse may send other staff to help person if safe for the dialysis patients.)

- ✓ Stay with person until help arrives
- ✓ Complete an **SAS** report



Post Fall Huddle

Party Involved / Notified / Witnesses

New Work done on file Follow-up

General

Date: 12-14-2020

Type: Work done on file

Sub-Type: Post-Fall Huddle Completed

Follow-Up Done By

Details

Form Letters: Please Selec

- Post-Fall Huddle Completed
- Chart Review
- Chief Medical Officer Sign-Off
- Chief Nursing Officer Sign-Off
- Clarification
- Comment
- Consultation
- Consultation-Insurance
- Consultation-Legal Counsel
- Consultation-Physician

Print | Download

Cancel | Add

When a Fall Occurs:

1. Unit holds a huddle at the Visual Management Huddle Board within 72 hours of the event
2. When possible include patient or their family member
3. Discuss root-cause of fall.
4. Implement countermeasures to prevent another fall from occurring.

Our Huddle Moments

- **Briefings** are short detailed IDT huddles to discuss the plan and the expected outcome.
  - Discuss safety concerns & "heads up."
  - Continue with the goal of creating a culture of safety, reduce the risks of falls, and improve quality of care.

- **Debriefings** are concise IDT huddles with exchange of ideas that occur *after* occurrence of the fall:
  - Identify what happened
  - What the team members learned
  - Properly identify high risk patients – use yellow sticker on NS bag

Remember The Nursing Process!

Assessment
Information collection/ gathering data

Diagnosis
Information interpretation
Stating problems & strengths

Outcome/ Planning
Setting nursing goals desired outcomes and planning interventions

Implementation
Performing nursing interventions

Evaluation
Patient's status and effectiveness of nursing interventions

The steps of the nursing process are interrelated, forming a continuous circle of thought and action that is both dynamic and cyclic (Doenges & Moorhouse, 2008 a+b)

References (1 OF 2)

- *CDC (1)*. (2017, February 10). Retrieved from Older Adult Fall Prevention: https://www.cdc.gov/falls/facts.html

- *CDC (2)*. (2020, September 16). Retrieved from STEADI: Empowering Healthcare Providers to Reduce Fall Risk: https://www.cdc.gov/steadi/provider-training/index.html

- Doenges, M., & Moorhouse, M. (2008). *Application of Nursing Process and Nursing Diagnosis* (Fifth ed.).

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Questions?