Fall Management Guideline

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by the

Best Practice Committee of the
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HCANJ Best Practice Committee's

Fall Management Guideline

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Disclaimer: This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use by your organization, it should be reviewed by counsel knowledgeable concerning applicable federal and state health care laws and rules and regulations. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

This Best Practice Guidelines is offered to nursing facilities, assisted living communities, residential health care facilities, adult day health services providers and other professionals for informational and educational purposes only.

The Health Care Association of New Jersey (HCANJ), its executers, administrators, successors, and members hereby disclaim any and all liability for damage of whatever kind resulting from the use, negligent or otherwise, of all Best Practice Guidelines herein.

This Best Practice Guideline was developed by the HCANJ Best Practice Committee ("Committee"), a group of volunteer professionals actively working in or on behalf of health care facilities in New Jersey, including skilled nursing facilities, sub-acute care and assisted living providers.

The Committee's development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strives to develop guidelines that are consistent with these principles:

- Relative simplicity
- Ease of implementation
- Evidence-based criteria
- Inclusion of suggested, appropriate forms
- Application to various long term care settings
- Consistent with statutory and regulatory requirements
- Utilization of MDS (RAI) terminology, definitions and data collection

Appropriate staff (Management, Medical Director, Physicians, Nurse-Managers, Pharmacists, Pharmacy Consultants, Interdisciplinary Care Team) at each facility/program should develop specific policies, procedures and protocols to best assure the efficient, implementation of the Best Practice Guideline's principles.

The Best Practice Guidelines usually assume that recovery/rehabilitation is the treatment or care plan goal. Sometimes, other goals may be appropriate. For example, for patients receiving palliative care, promotion of comfort (pain control) and dignity may take precedence over other guideline objectives. Guidelines may need modification to best address each facility, patient and family's expectations and preferences.

Recognizing the importance of implementation of appropriate guidelines, the Committee plans to offer education and training. The HCANJ Best Practice Guidelines will be made available at www.hcanj.org.

HCANJ Best Practice Committee

Fall Management Guidelines

MISSION STATEMENT

The Falls Management Program is designed to assist personnel to reduce falls, minimize injury and ultimately improve the quality of life of our residents.

This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

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DEFINITION

A *fall* is defined as an occurrence characterized by the failure to maintain an appropriate lying, sitting or standing position, resulting in an individual's abrupt, undesired relocation to the ground. The definition of a fall extends to and includes following factors:

- An episode in which a resident has lost his/her balance and would have fallen were it not for staff intervention.
- The presence or absence of a resultant injury; a fall without injury is a fall.
- The distance to the next lower surface (in this case, the floor) does not determine the incidence of a fall. (i.e. bed or mattress close to the floor)

OBJECTIVES

- Limit and/or prevent the occurrence of falls within the parameters that can be controlled through structured program interventions.
- Minimize the severity of injuries sustained by an elderly individual resulting from a fall.
- Provide the professional staff with standards of practice that will enable them to perform and teach effectively.
- Educate the resident, family and direct care and ancillary staff.
- Limit the liability and financial risk to the facility.

PROGRAM OUTLINE

Each health care system is encouraged to use this comprehensive guideline to outline and further define its' program specific, fall management policy and procedures.

I. KEY ELEMENTS TO A FALL MANAGEMENT PROGRAM

- A. Facility leadership approval and participation
- B. Assessments
- C. Dynamic treatment plan
    1. Role of Interdisciplinary Team or Resident Review Team
    2. Use of non-pharmaceutical interventions

D. Appropriate and necessary use of devices (enablers, restraints)
E. Re-assessments, implementation and evaluation of treatment plan
F. Education/awareness

II. DETAILED ELEMENTS

A. Assessments

1. Clinical Assessment
    a) assessment form - recommend rating scale
    b) completed by Registered Nurse
        (1) time of completion
        (2) admission fall risk assessment completed within 24 to 48 hours of admission
        (3) if indicated, comprehensive fall risk assessment within 14 to 21 days after admission
    c) frequency of reassessment:
        (1) upon a fall
        (2) significant change likely to increase fall prediction factors
        (3) quarterly for skilled nursing and sub-acute care facilities
        (4) semi-annually for assisted living communities
2. Rehabilitation Assessment
    a) completed by PT or OT
    b) form: (e.g. Tinetti Gait and Balance Tool or Berg Balance Scale)
    c) transfer evaluation
    d) evaluate for vestibular imbalance
    e) time of completion (recommend 24 to 48 hours after referral)
    f) frequency of re-evaluation (see assessments)
3. Continence Protocol As Indicated
    a) toilet schedule
    b) bladder training as indicated
4. Mental Status Assessment
    a) complete mini-mental status assessment
    b) recall
    c) judgment (safety awareness)
5. Pain Assessment (see Best Practice Guidelines and Opioid Guidance)
    a) opiod use
    b) chronic unrelieved pain
    c) acute exacerbation of usually controlled pain
    d) new pain

6. Review record of diagnoses which contribute to increased falls risk, such as
    a) Orthostatic Hypotension
    b) Osteopenia
    c) Osteoporosis
    d) History of falls
    e) Dementia
    f) Delirium
    g) Sensory Impairment (hearing, touch, sight)
    h) Parkinsons
    i) Atrial fibrillation
    j) Seizure disorders
    k) Arthritis
    l) Vertigo
    m) CVA
    n) Loss of Limb(s)
    o) Fractures
    p) Anemia
    q) Wandering
    r) Anger
7. Pharmacological Assessment and Review
    a) completed by pharmacy consultant or physician
    b) review of medication profile
    c) new or changed medications
    d) use of off label antipsychotics
    e) use of benzodiazepines
    f) inappropriate medications for the elderly Review Beers Criteria
    g) adverse or idiosyncratic medication reactions or interactions
8. Environment Assessment
    a) physical room layout
    b) equipment and assistive devices
    c) lighting
    d) other
9. Analysis/Assess Level of Risk Assessment
    a) identify level of risk based on collective assessments and professional judgment.

B. Dynamic Treatment Plan

1. Specific interventions based on results of fall assessment, and client preferences. The interdisciplinary/resident review team members must address:

a) resident, staff and family teaching
b) room modifications
c) resident's daily routines
d) mental status/behaviors
e) physical limitations
(1) ADL skills
(2) continence
f) pain
g) medication use
h) non-pharmaceutical interventions in place
i) consistent appropriate and proper uses of assistive or protective devices, electric scooters, etc., based on assessments

2. Updated information communicated to the staff, resident and family
a) Staff
(1) general classification system identifying resident's potential to fall
(2) summary of assessments/changes in service or care plan
(3) verbal and written reports
b) residents: one to one education and review
c) families: care/status review conferences, attendance/participation

C. Evaluation
1. Post fall evaluation
a) Fall Management Investigation or Post Fall Assessment Tool
(1) physical assessment
(2) contributing factors to fall
(3) medication changes (new or discontinued)
(4) mental status changes
(5) new diagnoses

2. Reporting mechanism/tracking of falls within the facility
a) a facility “Facility Fall Summary/Analysis”
b) action of the interdisciplinary team
(1) timely modifications to the treatment plan
(2) family/resident conferences
(3) physical adaptations to room, wheelchair and/or walking devices
c) collective review, identification and analysis of trends in resident falls throughout the facility (see E. Quality Improvement, Pg. 9)

3. Facility protocol may include falls management review and analysis by the safety committee, falls committee, IDC plan committee, quality improvement committee or other established interdisciplinary group.

D. Education/Awareness

1. Falls Program In-service

a) Staff members

(1) Intervals for review of Fall Management Program:

(a) upon orientation

(b) semiannual

(c) post fall evaluation as necessary

(2) Contents of review:

(a) policies and procedures

(b) documentation standards

b) Resident

(1) Intervals for review of Fall/Safety Information:

(a) admission

(b) care plan meetings

(c) quarterly resident population education on fall management

(d) after a fall

(2) Contents of review:

(a) instructions and information concerning safety awareness

(b) proper use of call bells, walking devices, wheelchairs and other assistive devices

c) Family

(1) Intervals for review of Fall/Safety Information:

(a) upon admission of the resident

(b) address with family as resident presents need to discuss

(c) upon discharge of resident

(2) Contents of review:

(a) reasonable expectations from the facility

(b) how they can assist

d) Department of Health and Senior Services

(1) Inform the department of health personnel about the facility's Fall Program and what is the level of implementation

E. Quality Improvement

1. Collect falls data (including near miss data)
    a. Post fall tool
    b. Falls summary report
        (1) conduct interdisciplinary analysis of information to gain helpful knowledge
        (2) review and revise policies and procedures as appropriate
            (a) retrain staff on new policies and procedures
2. Complete Facility Falls Data summary document
    a. Analyze information
    b. Revise policies and procedures as appropriate
        (1) retrain staff on new policies and procedures

BEST PRACTICE PROGRAM

— Falls Management —

BEST PRACTICE TOOLS:

ASSESSMENT, PLAN OF CARE

AND INVESTIGATION FORMS

- Fall Risk Predictive Factors Assessment
- Falls Management: Optional Initial Plan of Care
- Falls Management Investigation—Post Fall Tool
- Falls Management Post Fall Assessment Tool

FALL RISK PREDICTIVE FACTORS ASSESSMENT

INSTRUCTIONS: Assess the resident status in the eight clinical condition parameters listed below (A-H) by assigning the corresponding score which best describes the resident in the appropriate assessment column. Add the column of numbers to obtain the Total Score. If the total score is 10 or greater, the resident may be considered at *HIGH RISK* for potential falls. If indicated, initiate a plan of care to reduce the likelihood of a fall and/or severity of fall related injury. (*SEE OTHER SIDE FOR OPTIONAL PLAN OF CARE*)

	PARAMETER	SCORE	ASSESSMENT	1	2	3	4
mental status	**A** Level of Consciousness/ Mental Status	0	ALERT, ORIENTED, RELIABLE SAFETY AWARENESS; OR COMATOSE				
		2	DIMINISHED SAFETY AWARENESS				
		4	POOR RECALL, JUDGEMENT, SAFETY AWARENESS				
mobility / continence	**B** Ambulatory Elimination Status 2 or higher, may assess for continence protocol.	0	AMBULATORY / CONTINENT				
		2	IMPAIRED MOBILITY / CONTINENT (assist with toileting)				
		4	AMBULATORY / INCONTINENT				
	C Gait / Balance If total is greater than 1, refer to Rehab Department for screening.		To assess the resident's Gait / Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; make a turn. Score each area or enter N/A for "not assessed."				
		0	GAIT / BALANCE normal				
		1	Balance problem while standing				
		1	Balance problem while walking				
		1	Decreased muscular coordination				
		1	Change in gait pattern when walking through doorway				
		1	Jerking or unstable when making turns				
		1	Requires use of assistive devices (cane, w/c, walker, furniture, etc.)				
medical status / history	**D** Vision Status	0	ADEQUATE (with or without glasses)				
		2	POOR (with or without glasses)				
		4	LEGALLY BLIND				
	E Orthostatic Blood Pressure (Systolic)	0	NO NOTED DROP between lying and standing				
		2	Drop LESS THAN 20mm Hg between lying and standing				
		4	Drop MORE THAN 20mm Hg between lying and standing				
	F Falls History (past 3 months)	0	NO FALLS in past 3 months				
		2	1-2 FALLS in past 3 months				
		4	3 OR MORE FALLS in past 3 months				
	G Medications If total is greater than 2, may refer to Physician or Pharmacy Consultant for assessment.		Respond below based on following types of medications: Anesthetics, Anthistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics.				
		0	NONE of these medications taken currently or within last 7 days				
		2	TAKES 1-2 of these medications currently and/or within last 7 days				
		4	TAKES 3-4 of these medications currently and/or within last 7 days				
		1	If resident has had a change in medication and/or change in dosage in the past 5 days—score 1 additional point				
	H Predisposing Diseases / Conditions		Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's Disease, Loss of Limb(s), Seizures, Arthritis, Osteoporosis, Fractures, Dementia, Delirium, Anemia, Wandering, Anger.				
		0	NONE PRESENT				
		2	1-2 PRESENT				
		4	3 OR MORE PRESENT				
	Total score of 10 or higher may represent HIGH RISK		**TOTAL SCORES**				

ASSESSORS

1 Name (print) :_____
Assessor Signature:_____ Assess. Date:

2 Name (print) :_____
Assessor Signature:_____ Assess. Date:

3 Name (print) :_____
Assessor Signature:_____ Assess. Date:

4 Name (print) :_____
Assessor Signature:_____ Assess. Date:

RESIDENT Last_____ First_____ Room # :_____

FALLS MANAGEMENT: OPTIONAL INITIAL PLAN OF CARE

NOTE: Interventions includes general standards of care that should be considered, facility/program/unit specific protocols and environmental safety features. The medical record documents — physician's orders, progress notes, therapy notes, nurses notes, and consultation reports may include additional interventions that are intended to manage underlying conditions and circumstances that are predictive of falls. The below, resident-specific interventions are a guide. Actual care and services may vary in accordance with specific circumstances. **DIRECTIONS:** COMPLETE ALL INTERVENTION CATEGORIES THAT APPLY.

GOALS (on-going, may not be date specific)

1. to reduce incidence of falls and severity of fall related injury.
2.
3.

SELECTED INTERVENTIONS

mental status

A LEVEL OF CONSCIOUSNESS / MENTAL STATUS

☐Behavioral management / modification: _____
_____

☐Movement sensor alarm:
☐bed alarm ☐chair alarm ☐other_____
☐alarm test and battery check per protocol

☐Least restrictive restraint:
☐bed_____ ☐chair_____
☐other_____

☐Assistive devices:
☐wheelchair ☐walker ☐meri-walker
☐other_____

☐Increase assistance and surveillance:
☐locate near station / staff when out of bed
☐toilet per B & B assessment
☐other_____

☐Proactively promote comfort:
☐pain medication ☐other_____

☐Review Medications: ☐yes, date ____/____/____ ☐no

☐Medical Consultation: ☐yes, date ____/____/____ ☐no
☐Psychiatric Consultation: ☐yes, date ____/____/____ ☐no

mobility / continence

B AMBULATORY ELIMINATION STATUS
C GAIT / BALANCE

☐PT/OT assessment and treatment _____
_____
_____

☐Restorative nursing (exercise / ambulation) _____
_____

☐Increase help with ADLs (activities of daily living): _____
_____
_____

☐Assistive devices:
☐cane ☐crutches ☐walker ☐meri-walker ☐wheelchair
☐Adjust height of: ☐bed ☐chair
☐other_____

☐Protective devices:
☐hip protector ☐head helmet protector
☐in bed protector ☐out of bed protector
☐other_____

☐Transfer:
☐no assistance ☐one person ☐two person ☐other_____
☐sliding board ☐other device: _____
_____

medical status / history

Environmental Modifications:
☐instruct resident to call for help before getting out of bed
☐bed in lowest position and wheels locked
☐bedrails up: ☐left side ☐right side
☐brighter lighting ☐night light
☐personal care items within arm length (cordless telephone, optical / hearing devices, mobility aids and assistive devices)
☐Footwear: _____
☐other_____
_____
_____

D VISION AND HEARING STATUS

☐Vision intervention:
☐corrective eyewear_____
☐eyewear within arms reach
☐Encourage resident to wear glasses
☐modify lighting
☐modify contrast colors
☐other_____

E ORTHOSTATIC BLOOD PRESSURE (SYSTOLIC)

☐Low blood pressure:
☐instruct to change position slowly
☐instruct to sit on edge of bed and dangle feet before standing
☐instruct to use dorsiflexion (flexion of the foot in an upward direction) before standing
☐instruct not to tilt head backwards

☐If medication change:
☐monitor blood pressure while lying to sitting; sitting to standing. Inform physician.

☐Other interventions:
☐TED hose (thromboembolic disease support hose)
☐promote adequate hydration
☐other_____
_____

F FALLS HISTORY (PAST 3 MONTHS)
G MEDICATIONS
H PREDISPOSING DISEASES / CONDITIONS

☐monitor and report changes in behavior (anxiety, sleep, patterns, behavior, mood, etc.)
☐Monitor and report drug side effects (See Mental Status)
☐Monitor routines:
☐No caffeine after 4 pm
☐Up at night w/supervision
☐comfort measures, good hygiene
☐pain management
☐regular exercise routine
☐limit napping
☐relaxing bed routine
☐individualized toileting at night
☐other:_____
_____

Who Completed this section

Name (print) :_____
Assessor Signature:_____ Assess. Date:

RESIDENT

Last_____ First_____ Middle Int.____ Chart # :_____

Rev. 03/2007

FALLS MANAGEMENT INVESTIGATION — POST FALL TOOL

Resident Name_____ Age_____ Living Quarters Room #_____

Date of fall ____/_____/_____ Day of week_____ Time_____ AM or PM

1. Was this fall observed? ☐No ☐Yes *If yes*, by whom: 1._____
(name and title of individual)
2. Location of fall (be as exact as possible) _____
_____
3. Was the Resident alone at the time of the fall? ☐Yes ☐No
4. What was the reason for the Resident to be in that location?_____
_____
5. Including this fall, what are the number of falls past 3 months? ☐None ☐One ☐Two ☐Three ☐Other:____
6. Were protective or safety devises in use at the time of the fall? ☐No
☐Yes ☐If yes, give detail:_____
7. Investigate the surroundings where the incident occurred for any evidence of the following:

Clue	☑	Yes	No	Clue	☑	Yes	No
Water spills?				Resident in a hurry? *If yes*, explain why:			
Clutter on the floor?				Resident not using cane/walker as MD ordered?			
Phone cords/TV cords lying about?				Improper footwear?			
Poor lighting?				Clothing got in the way?			
Improper bed height?				Resident using incontinent supplies at time of fall?			
Other furniture involved?				Resident became tired?			
Wheelchair unlocked?				Resident reaching for items?			
Wheelchair foot-rests in the way?				Other:			

8. Has the Residents health care status changed? Answer the following questions: ☑
   1. Do the "clues" reflect any *environmental factors* that could be involved in this fall?
   2. Do the "clues" reflect any *health care factors* that could be involved in this fall?

Clue	☑	Yes	No	Clue	☑	Yes	No
New/increase/decrease in medications?				Decrease in fluid intake?			
Weakness/fatigue?				Recent fever/cough/cold?			
Dizziness?				Changes in diagnosis status?			
Changes in blood pressure?				Changes in mental status?			
Recent return from hospital?				Changes in behaviors?			
Recent weight loss?				Changes in mobility status?			
Pain?				Recent/Change in lab. Values: Hb., bloodsugar, pulse O2.			

   3. If the resident has had more than one fall, are there any similarities? (time, place, resident activity)
   4. How do the "clues" that you have found, relate to each other?
   5. Previous fails: a) How many have there been in the past 3 months? b) Where did they occur? c) What time did they occur? d) What actions were set in place after the previous fall(s)?
   6. Is there a need to re-educate the patient, family and/or staff?
   7. Has the patient's/resident's Care Plan been updated?

Who completed this form:
Name (print) :_____ Signature:_____ Date:_____

FALLS MANAGEMENT - POST FALL ASSESSMENT TOOL

Resident Name_____ Age_____ Living Quarters Room #_____

Admitting Date____/_____/_____ Admitting Dx_____ Current Dx_____

Date of fall ____/_____/_____ Day of week_____ Time_____ AM or PM

Assigned Caregiver(s): 1._____
(name and title of individual)

2._____
(name and title of individual)

1. Was this fall observed? ☐No ☐Yes *If yes*, by whom:

   1._____ 2._____
   (name and title of individual) (name and title of individual)

2. Was the resident identified as "High Risk" prior to the fall? ☐No ☐Yes

3. Resident vital signs:

Usual vital signs *prior to* the fall:	B/P Lying:	Pulse:
	B/P Sitting:	Pulse:
	B/P Standing:	Pulse:
Vital signs at *time of* the fall:	B/P Lying:	Pulse:
	B/P Sitting:	Pulse:
	B/P Standing:	Pulse:
Vital signs—*minutes after* the fall:	B/P Lying:	Pulse:
	B/P Sitting:	Pulse:
	B/P Standing:	Pulse:

4. Does the resident have a history of falls? ☐No ☐Yes *If yes*, list dates of all previous falls for the past 12 months:
   - Date of fall_____/_____/_____ Time_____ AM or PM
   - Date of fall_____/_____/_____ Time_____ AM or PM
   - Date of fall_____/_____/_____ Time_____ AM or PM

5. List the *life safety measures* in place prior to this current fall: _____
   _____

6. Ask the following questions of the *resident "immediately" after their fall*: " Why do you think you fell? "
   Resident Response: _____
   _____

7. Ask the following questions of the *resident immediately after their fall*: ☑

	Yes	No		Yes	No
Were you hungry?			Did you need to use the bathroom?		
Were you in pain?			Other:		
Were you bored?					

8. What footwear did the resident have on: ☑

Barefoot		Slippers	
Shoes		Other:	

Confidential Document Continuous Quality Improvement (CQI)
This form is for investigative and QI purposes only, and need not be included as part of resident record.

9. What was the resident doing at the time of this current fall: ☑

	Yes	No
Getting out of bed?		
Going to the bathroom?		
Looking for something?		
Getting up from chair?		
Going to the dining room?		

Other:

10. Location of this current fall: ☑

Activity Room		Day Room		Shower		Other:
Bath Room		Dining Room		Toilet		
Bed Room		Hall		Transferring		
Commode		Outside		Wheelchair		

11. Was a restraint used during this incident? ☑

None		Waist restraint		Other:
Geri Chair/Lap Board		Vest restraint		
Side rails		Mittens		
Wrist restraint				

12. Was restraint applied properly prior to this incident? ☐Yes ☐No
If no, please describe: _____

_____

Physician order:_____

_____

13. Mechanical/Assistive Devices:

WHAT *MECHANICAL* DEVICES WERE IN USE:	☑		YES	NO
Chair alarm		Was chair alarm working at time of incident?		
Bed alarm		Was bed alarm working at time of incident?		
Mobility monitor		Was mobility monitor working at time of incident?		
Other mechanical device in use:		Was other mechanical device working at time of incident?		
WHAT *ASSISTIVE* DEVICES WERE IN USE:	☑		YES	NO
Cane ☐straight ☐hemi ☐quad		Was cane in good repair?		
Crutches		Were crutches in good repair?		
Walker		Was walker in good repair?		
Wheelchair		Was wheelchair in good repair?		
Geri-Chair		Was Geri-chair in good repair?		
Geri Chair Lap Board		Was Geri-care lap board in good repair?		

14. Mental Status of resident: ☑

Mental Status *prior to fall*:	YES	NO	Mental Status *following the fall*:	YES	NO
Alert			Alert		
Oriented			Oriented		
Disoriented			Disoriented		
Confused			Confused		
Unable to follow directions			Unable to follow directions		
Other:			Other:		

15. Physical Status of resident prior to the fall: ☑

Physical Status *prior to fall*:	YES	NO	N/A
Unsteady gait			
Glasses on			
Incontinence			
Weakness/fatigue			
Hearing impairment			
Dizziness			
Pain			

Physical Status *prior to fall*:	YES	NO	N/A
Impaired mobility/transfer			
Visual impairment			
Hearing aid working			
Recent acute illness			
Recent/change in lab. Values: Hb., bloodsugar, pulse 02			
Other:			

16. Environmental Status at time of the fall: ☑

Environmental Status *at time of fall*:	YES	NO	N/A	Environmental Status *at time of fall*:	YES	NO	N/A
Call bell within resident's reach				Call bell on at time of fall			
Bed locked				Room light on			
Wheelchair locked				Floor wet			
Night light on				Patterned carpets / Throw rugs			
Uneven floor surface				Power/Phone/TV Cords			
Glare on floor				Other:			

17. Medication Status: ☑

	YES	NO	N/A		YES	NO	N/A
Diuretic				Cardiac			
Antihypertensive				Antibiotic			
Psychotropic				Other:			
Laxative							

18. List all new medications prescribed/administered to the resident within the past week: _____

_____

19. Describe the general health of the resident in the hours, days and week before the fall: _____

_____

20. Is there a need to re-educate the patient/resident, family and staff? ☐No ☐Yes

21. Has the resident's Care Plan been updated? ☐No ☐Yes

BEST PRACTICE PROGRAM

— Falls Management —

TINETTI ASSESSMENT TOOLS

- Description
- Balance
- Gait

TINETTI ASSESSMENT TOOL: *Description*

POPULATION……...Adult population, elderly patients

DESCRIPTION……..The Tinetti Assessment Tool is a simple, easily administered test that measures a patient's gait and balance. The test is scored on the patient's ability to perform specific tasks.

MODE OF ADMINISTRATION……..The Tinetti Assessment Tool is a task performance exam.

TIME TO COMPLETE……..10 to 15 minutes

TIME TO SCORE……..Time to score is included in time to complete

SCORING……...Scoring of the Tinetti Assessment Tool is done on a three point ordinal scale with a range of 0 to 2. A score of 0 represents the most impairment, while a 2 would represent independence of the patient. The individual scores are then combined to form three measures; an overall gait assessment score, an overall balance assessment score, and a gait and balance score.

INTERPRETATION……..The maximum score for the gait component is 12 points. The maximum score for the balance component is 16 points. The maximum total score is 28 points. In general, patients who score below 19 are at a high risk for falls. Patients who score in the range of 19-24 indicate that the patient has a risk for falls.

RELIABILITY……...Interrater reliability was measured in a study of 15 patients by having a physician and a nurse test the patients at the same time. Agreement was found on over 85% of the items and the items that differed never did so by more than 10%. These results indicate that the Tinetti Assessment Tool has good interrater reliability.

VALIDITY…….Not reported

REFERENCES……Lewis C. Balance, Gait Test Proves Simple Yet useful. *P.T. Bulletin* 1993; 2/10:9 & 40.

Tinetti ME. Performance-Oriented Assessment of Mobility Problems in Elderly Patients. *JAGS* 1986; 34:119-126.

TINETTI ASSESSMENT TOOL: BALANCE

Resident's Name: _____

Initial Instructions: Subject is seated in a hard, armless chair. The following maneuvers are tested.

TASK	DESCRIPTION OF BALANCE	Possible	Score	Date	Score	Date	Score	Date
1. SITTING BALANCE	Leans or slides in chair	**0**						
	Steady, safe	**1**						
2. ARISES	Unable *without* help	**0**						
	Able, *uses* arms to help	**1**						
	Able *without* using arms	**2**						
3. ATTEMPTS TO ARISE	Unable without help	**0**						
	Able, requires > 1 attempt	**1**						
	Able to rise > 1 attempt	**2**						
4. IMMEDIATE STANDING BALANCE (first 5 seconds)	Unsteady (swaggers, moves feet, trunk sway)	**0**						
	Steady but *uses* walker or other support	**1**						
	Steady *without* walker or other support	**2**						
5. STANDING BALANCE	Unsteady	**0**						
	Steady but wide stance (medical heels 4 inches apart) and uses cane or other support	**1**						
	Narrow stance without support	**2**						
6. NUDGED (subject at max position with feet as close together as possible, examiner pushes lightly on subject's sternum with palm of hand 3 times.	Begins to fall	**0**						
	Staggers, grabs, catches self	**1**						
	Steady	**2**						
7. EYES CLOSED (at max position - see #6 above)	Unsteady	**0**						
	Steady	**1**						
8. TURNING 360 DEGREES	Discontinuous steps	**0**						
	Continuous steps	**1**						
	Unsteady (grabs, swaggers)	**0**						
	Steady	**1**						
9. SITTING DOWN	Unsafe (misjudged distance, falls into chair)	**0**						
	Uses arms or not a smooth motion	**1**						
	Safe, smooth motion	**2**						
			BALANCE SCORES:					
			Rate 1		**Rate 2**		**Rate 3**	

Date of Assessment	Assessor Signature and Title	Location of Resident During Assessment
1		
2		
3		

TINETTI ASSESSMENT TOOL: GAIT

Resident's Name: _____

Initial Instructions: Subject stands with examiner, walks down hallway or across the room, first at "usual" pace, then back at "rapid", but safe" pace (using usual walking aids).

TASK	DESCRIPTION OF BALANCE	Possible	Score	Date	Score	Date	Score	Date
10. INITIATION OF GAIT (immediately after told to "go")	Any hesitancy or multiple attempts to start	**0**						
	No hesitancy	**1**						
11. STEP LENGTH & HEIGHT	RIGHT swing foot does not pass left Stance foot with step	**0**						
	RIGHT foot passes left stance foot	**1**						
	RIGHT foot does not clear floor completely with step	**0**						
	RIGHT foot completely clears floor	**1**						
	LEFT swing foot does not pass right stance foot with step	**0**						
	LEFT foot passes right stance foot	**1**						
	LEFT foot does not clear floor completely with step	**0**						
	LEFT foot completely clears floor	**1**						
12. STEP SYMMETRY	RIGHT AND LEFT step length *not* equal (estimate)	**0**						
	RIGHT AND LEFT step *appear* equal	**1**						
13. STEP CONTINUITY	Stopping or discontinuity between steps	**0**						
	Steps appear continuous	**1**						
14. PATH (estimated in relation to floor tiles, 12 inch diameter. Observe excursion of 1 foot over about 10 feet of the course)	Marked deviation	**0**						
	Mild/moderate deviation or uses walking aid	**1**						
	Straight without walking aid	**2**						
15. TRUNK	Marked sway or uses walking aid	**0**						
	No sway - but flexion of knees or back, or spreads arms out while walking	**1**						
	No sway, no flexion, no use of arms, and no use of walking aid	**2**						
16. WALKING STANCE	Heels apart	**0**						
	Heels almost touching while walking	**1**						
		SCORE—**GAIT**						
		SCORE—**BALANCE**						
		SCORE—**BALANCE AND GAIT**						

	Rate 1	Rate 2	Rate 3

Date of Assessment	Assessor Signature and Title	Location of Resident During Assessment
1		
2		
3		

BEST PRACTICE PROGRAM

— Falls Management —

BERG BALANCE MEASURE

- Description
- Balance Scale

BERG BALANCE MEASURE: *Description*

POPULATION.……...Elderly patients, balance

DESCRIPTION.……..The Berg Balance Measure was designed to test elderly patients level of balance. The test consists of 14 balance items which have been deemed safe for elderly patients to perform.

MODE OF ADMINISTRATION……...The Berg Balance Measure is a task performance exam.

COMPLETION —

TIME TO COMPLETE……...15 to 20 minutes

TIME TO SCORE……...The test is scored while it is administered.

SCORING……...The independent items are scored on a five point ordinal scale; where 0 indicates the patients inability to perform the task and 4 represents independence. The individual points are then summed to achieve a total score.

INTERPRETATION……..The higher the patient scores on the balance measure the more independent the patient is.

BERG BALANCE MEASURE: BALANCE SCALE

Patient/Resident Name: _____ Date: _____

Location: _____ Rater: _____

General Instructions:
Please demonstrate each task and/or give instructions as written. When scoring, please record the lowest response category that applies for each item.

In most items, the subject is asked to maintain a given position for specific time. Progressively more points are deducted if the time or distance requirements are not met, if the subject's performance warrants supervision, or if the subject touches an external support or receives assistance from the examiner. Subjects should understand that they must maintain their balance while attempting the tasks. The choices of which leg to stand on or how far to reach are left to the subject. Poor judgment will adversely influence the performance and the scoring.

Equipment required for testing are a stopwatch or watch with a second hand, and a ruler or other indicator of 2, 5 and 10 inches (5, 12.5 and 25 cm). Chairs used during testing should be of reasonable height. Either a step or a stool (of average step height) may be used for item #12.

ITEM DESCRIPTION	SCORE (0—4)
1. Sitting to standing	
2. Standing unsupported	
3. Sitting unsupported	
4. Standing to sitting	
5. Transfers	
6. Standing with eyes closed	
7. Standing with feet together	
8. Reaching forward with outstretched arm	
9. Retrieving object from floor	
10. Turning to look behind	
11. Turning 360 degrees	
12. Placing alternate foot on stool	
13. Standing with one foot in front	
14. Standing on one foot	
TOTAL	

Circle appropriate numbers.

1. SITTING TO STANDING

Instructions: Please stand up. Try not to use your hands for support.

4 able to stand without using hands and stabilize independently
3 able to stand independently using hands
2 able to stand using hands after several tries
1 needs minimal aid to stand or to stabilize
0 needs moderate or maximal assist to stand

2. STANDING UNSUPPORTED

Instructions: Please stand for two minutes without holding.

4 able to stand safely 2 minutes
3 able to stand 2 minutes with supervision
2 able to stand 30 seconds unsupported
1 needs several tries to stand 30 seconds unsupported
0 unable to stand 30 seconds unassisted

Note: If a subject is able to stand 2 minutes unsupported, score full points for sitting unsupported. Proceed to item #4.

3. SITTING WITH BACK UNSUPPORTED BUT FEET SUPPORTED ON FLOOR OR ON A STOOL

Instructions: Please sit with arms folded for 2 minutes.

4 able to sit safely and securely 2 minutes
3 able to sit 2 minutes under supervision
2 able to sit 30 seconds
1 able to sit 10 seconds
0 unable to sit without support 10 seconds

4. STANDING TO SITTING

Instructions: Please sit down.

4 sits safely with minimal use of hands
3 controls descent by using hands
2 uses back of legs against chair to control descent
1 sits independently but has uncontrolled descent
0 needs assistance to sit

5. TRANSFERS

Instructions: Arrange chair(s) for a pivot transfer. Ask subject to transfer one way toward a seat with armrests and one way toward a seat without armrests. You may use two chairs (one with and one without armrests) or a bed and a chair.

4 able to transfer safely with minor use of hands
3 able to transfer safely definite need of hands
2 able to transfer with verbal cueing and/or supervision
1 needs one person to assist
0 needs two people to assist or supervise to be safe

Patient's Name: _____ Date: _____

Location: _____ Rater: _____

6. STANDING UNSUPPORTED WITH EYES CLOSED

Instructions: Please close your eyes and stand still for 10 seconds.

4 able to stand 10 seconds safely
3 able to stand 10 seconds with supervision
2 able to stand 3 seconds
1 unable to keep eyes closed 3 seconds but stays steady
0 needs help to keep from falling

7. STANDING UNSUPPORTED WITH FEET TOGETHER

Instructions: Place your feet together and stand without holding.

4 able to place feet together independently and stand 1 minute safely
3 able to place feet together independently and stand for 1 minute with supervision
2 able to place feet together independently and to hold for 30 seconds
1 needs help to attain position but able to stand 15 seconds feet together
0 needs help to attain position and unable to hold for 15 seconds

8. REACHING FORWARD WITH OUTSTRETCHED ARM WHILE STANDING

Instructions: Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at end of fingertips when arm is at 90 degrees. Fingers should not touch the ruler while reaching forward. The recorded measure is the distance forward that the finger reach while the subject is in the most forward lean position. When possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)

4 can reach forward confidently >25 cm (10 inches)
3 can reach forward >12.5 cm safely (5 inches)
2 can reach forward >5 cm safely (2 inches)
1 reaches forward but needs supervision
0 loses balance while trying/ requires external support

9. PICK UP OBJECT FROM THE FLOOR FROM A STANDING POSITION

Instructions: Pick up the shoe/slipper which is placed in front of your feet.

4 able to pick up slipper safely and easily
3 able to pick up slipper but needs supervision
2 unable to pick up but reaches 2-5cm (1-2 inches) from slipper and keeps balance independently
1 unable to pick up and needs supervision while trying
0 unable to try/needs assist to keep from losing balance or falling

10. TURNING TO LOOK BEHIND OVER LEFT & RIGHT SHOULDERS WHILE STANDING

Instructions: Turn to look directly behind you over toward left shoulder. Repeat to the right. Examiner may pick an object to look at directly behind the subject to encourage a better twist turn.

4 looks behind from both sides and weight shifts well
3 looks behind one side only other side shows less weight shift
2 turns sideways only but maintains balance
1 needs supervision when turning
0 needs assist to keep from losing balance or falling

BERG BALANCE MEASURE: BALANCE SCALE (Page 3 of 4)

Patient/Resident Name: _____ Date: _____

Location: _____ Rater: _____

11. TURN 360 DEGREES

Instructions: Turn completely around in a full circle. Pause. Then turn a full circle in the other direction.

4 able to turn 360 degrees safely in 4 seconds or less
3 able to turn 360 degrees safely one side only in 4 seconds or less
2 able to turn 360 degrees safely but slowly
1 needs close supervision or verbal cueing
0 needs assistance while turning

12. PLACING ALTERNATE FOOT ON STEP OR STOOL WHILE STANDING UNSUPPORTED

Instructions: Place each foot alternately on the step/stool. Continue until each foot has touched the step/stool four times.

4 able to stand independently/safely & complete 8 steps in 20 seconds
3 able to stand independently and complete 8 steps >20 seconds
2 able to complete 4 steps without aid with supervision
1 able to complete >2 steps needs minimal assist
0 needs assistance to keep from falling/unable to try

13. STANDING UNSUPPORTED ONE FOOT IN FRONT

*Instructions: (*Demonstrate to subject) Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot. (To score 3 points, the length of the step should exceed the length of the other foot and the width of the stance should approximate the subject's normal stride width)

4 able to place foot tandem independently and hold 30 seconds
3 able to place foot ahead of other independently and hold 30 seconds
2 able to take small step independently and hold 30 seconds
1 needs help to step but can hold 15 seconds
0 loses balance while stepping or standing

14. STANDING ON ONE LEG

Instructions: Stand on one leg as long as you can without holding.

4 able to lift leg independently and hold >I 0 seconds
3 able to lift leg independently and hold 5-10 seconds
2 able to lift leg independently and hold = or >3 seconds
1 tries to lift leg unable to hold 3 seconds but remains standing independently
0 unable to try or needs assist to prevent fall

_____TOTAL SCORE of questions 1—14 (Maximum= 56)

Patient/Resident Name: _____ Date: _____

Location: _____ Rater: _____

BEST PRACTICE PROGRAM

— Falls Management —

CONFIDENTIAL QUALITY IMPROVEMENT (QI) FORMS

- Facility Falls Summary Report
- Facility Falls Data Summary
- Falls Management Guidelines Quantitative Measurement Record

Facility_____ Month Ending_____ Pg. __ of __

Facility Falls Summary Report Form

CONFIDENTIAL DOCUMENT FOR QUALITY IMPROVEMENT ANALYSIS ONLY.
Data is not risk adjusted and should not be used to compare among facilities.

Resident/ Patient Identifier	Location of Incident						Day	Time D—Day E— Eve. N—Night			Mental Status N—Normal / Oriented C—Confused D—Disoriented			Medication Code	Restraint Y / N	Equipment In Use Code	Injury Y / N	Injury Code
	RR	HW	BR	DR	OD	O		D	E	N	N	C	D					

CODE KEYS

LOCATION
- **RR** Resident Room
- **HW** Hallway
- **BR** Bathroom
- **DR** Dining Room
- **OD** Outdoor
- **O** Other. If other, detail:

MEDICATION
- **A** Antihypertensive
- **ANL** Analgesic
- **ANT** Antibiotic
- **C** Cardiac
- **D** Diuretic
- **H** Hypnotic
- **L** Laxative
- **P** Psychotropic
- **S** Sedating Anti-Depressant/Antihistamine
- **NEW** Medication in past 5 days ☐No ☐If yes, give detail:

EQUIPMENT IN USE
- **G** Geri Chair
- **HP** Hip Protector
- **LAP** Lap Buddy
- **SR** Side Rails
- **R** Restraint
- **TAB** Tab Monitors
- **O** Other. If other, detail:

INJURY CODE
- **C** Change in Care/Service Plan
- **FX** Fracture
- **ER** Emergency Room Visit
- **H** Hospitalization
- **S** Suture
- **SD** Subdural
- **O** Other. If other, detail:

Monthly Summary

Facility Falls Data Summary

CONFIDENTIAL DOCUMENT FOR QUALITY IMPROVEMENT ANALYSIS ONLY.
Data is not risk adjusted and should not be used to compare among facilities.

Facility_____ Month Ending_____

1. Total # of falls …….. _____
2. Total # of falls with injury …….. _____
3. Total # of residents who fell ……..…….. _____
4. Total # of residents with 2 or more falls……..…… _____

5. Total # of falls per resident computed only for residents who fell:
   _____ divided by _____ = …….. _____
   (Example: (total # of falls from #1 above) 14 Falls divided by (total # of residents who fell from #3 above) 10 residents = 1.4 Falls per residents who fell.)

6. For the month, total resident days:
   _____ x _____ = _____
   Average daily census multiplied by total days in the month = resident days.
   (Example: Average Daily Census 100 x 30 days = 3,000 Resident Days.)

7. Falls per 1,000 resident days:
   _____ x 1,000 = _____ divided by _____ = _____
   Total number of resident falls in one month from #1 above times 1,000, divided by total resident days from #6 above.
   (Example: 14 falls x 1,000 = 14,000 divided by 3,000 (total resident days) = 4.66 falls per 1,000 Resident Days.)

8. Falls With Injury per 1,000 resident days:
   _____ x 1,000 = _____ divided by _____ = _____
   Total number of resident falls with injuries in one month from #2 above times 1,000, divided by total resident days from #6 above.
   (Example: 2 falls with injury x 1,000 = 2,000 divided by 3,000 (total resident days) = 0.66 falls with injury per 1,000 Resident Days.)

Note: For the purposes of this report *"injury"* means: any fracture, any sutures, any need for hospitalization or other immediate medical attention, and any changes in functional ability requiring a change in Care Plan. *Injury does not include minor skin tears or bruises.*

CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT (QI)

Falls Management Guidelines Quantitative Measurement Record

Facility_____

Measurements Definitions	✓Check: ❑30 days ❑60 days ❑90 days Pre-implementation												
Total # *of falls* per 1,000 patient/ resident days per specified time period.		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Total # *of falls* <u>*with injury*</u> per 1,000 patient/ resident days per specified time period.													

Note: This quantitative data <u>*is not risk adjusted*</u> and is not intended to be used to compare different facilities.
A change in the number of falls, with or without injury, is not necessarily a direct indication of quality of care.

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