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Stepping UP to Stop Falls
Best Practice in Skilled Nursing Facilities

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Occupational Therapy Department
Greenville, NC

HOW WILL YOU STEP UP TO STOP FALLS?
OBJECTIVES

Define and discuss “Best Practice” in identifying and addressing falls and fear of falling risk factors and subsequent ramifications on occupational performance, affect, and quality of life of residents in skilled nursing facilities (SNF).

Demonstrate how to incorporate the STEADI into SNF practice.

Review specific screening tools and evaluations healthcare professionals may utilize with residents in SNF.

Generate strategies for the entire health care team in addressing falls and fear of falling as SNF residents transition from one environmental setting to another.

BEST PRACTICE OR EVIDENCE-BASED PRACTICE?

Best Practice

- Based on “best evidence” available
- Application of “recent, relevant, and helpful interventions based on research, in real-life practice”

Evidence-Based Practice

“integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

(Sackett D, 1996)

HCGNE (no date)
WHAT IS AN UNEXPLAINED FALL?

○ “event which results in a person coming to rest inadvertently on the ground or floor or other lower level”
○ Includes slips, trips, etc.
○ Does not include events that could occur for anyone at any age to fall
  ○ Seizure
  ○ Hit by a grocery cart

(World Health Organization [WHO], 2012)
WHAT WE KNOW ABOUT FALLS IN SNFs

- SNF must only report accidental falls among long-term (LT) stay residents
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
  - 10/1/16 post-acute falls data will begin to be collected (House Ways & Means, 2015; Leland, et al., 2015)
- Pervasive and problematic for the continuum of care among adults ≥ 65 years of age
- Falls may occur due to transition of continuum of care errors

WHAT WE KNOW ABOUT FALLS IN SNF

- 5% of adults > 65 or older live in SNF; yet account for 20% of all fall deaths
- 50-75% of long term SNF residents fall annually
- 10-20% have serious fall-related injuries
- 2-6% have fall-related fractures.
- 10-20% have serious injuries; 2-6% fractures
- Dementia? **Twice** the fall rate of SNF residents
- Modifiable and non-modifiable fall risks factors
WHAT WE KNOW ABOUT FALLS IN SNF

- 20% of residents fall within 1st 30 days of SNF post-acute admission
  - 4.7% of these have hip fracture
    - First 90 days after hospitalization and return back to SNF:
      - 24% had died
      - 7% returned home, but went back to SNF within 30 days
      - 46% transitioned to long-term care in SNF
      - ONLY 14% had successful community D/C

World Health Organization’s Risk Factor Falls Model

Note: content in green circles additional SNF fall risks

Behavioral risk factors
- Multiple medication use
- Excess alcohol intake
- Lack of exercise
- Inappropriate footwear

Environmental risk factors
- Poor building design
- Slippery floor and stairs
- Loose rugs
- Insufficient lighting
- Crooked or uneven sidewalks

Falls and fall-related injuries

Routines & Habits

- Mood & Pain
- Fear of falling

Recent SNF admit

Socioeconomic risk factors
- Low income and education levels
- Inadequate housing
- Lack of social interactions
- Limited access to health and social services
- Lack of community resources

Biological risk factors
- Age, gender and race
- Chronic illnesses (e.g., Parkinson, Arthritis, Osteoporosis)
- Physical, cognitive and affective capacities decline

- Decreased balance, gait, strength
- Mobility usage
- Visual/sensory deficits

(Bonner, 2006; CDC, 2015; Deandrea, et al., 2013; WHO, 2007)
WHAT WE DON’T KNOW ABOUT FALL PREVENTION IN SNF

- How pervasive falls and fear of falling are among post-acute and long-term residents, caregivers, and healthcare professionals?
- What specific evidence-based fall and fear of falling assessments are recommended for both post-acute and long-term residents?
- What specific evidence-based fall and fear of falling interventions/programs are recommended for post-acute and long-term?

WHERE DO YOU START?

INCREASE INDEPENDENCE WITH REGULAR EXERCISE.
MESSAGE ➞ FALL PREVENTION
MUST BEGIN AT ZERO HOUR ON
FIRST DAY OF SNF ADMISSION

It Takes a Village

- Geriatrician/PA
- Primary Care Provider
- Dentist
- Nurse/NP/CNA
- Pharmacist (geriatric)
- Occupational Therapist
- Occupational Therapy Assistant
- Physical Therapist
- Physical therapy Assistant
- Social Work
- Recreational Therapists
- Optometrist
- Audiologist
- Dietician
- Psychologist
- Non-health professionals
  - Housekeeping
  - Staff
  - Groundkeepers
  - Volunteers
Multi-factorial Approach

- Identify Fall History
- Identify Fall Risk Factors
- Identify Fear of Falling
- Education
- Multifactorial Team
- Individualized Approach

Multidisciplinary Team

- Multifactorial Approach
- Caregiver(s)
- Individualized Care Plan
### Hendrich II Fall Risk Model

**www.hartfordign.org**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Definition</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion/Near Total Pupillarity</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Symptomatic depression</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Alteration of consciousness</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Any prescribed antiepileptics</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Any prescribed benzodiazepines</td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

#### Get Up & Go Test

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to rise in a single movement</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pushes up, successful on one attempt</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Multiple attempts, not successful</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Unable to rise without assistance during test (or if medical order states the same or less rest is ordered)</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

* A score of 5 or greater = High Risk

#### Sample Risk Level

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>MFS Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Risk</td>
<td>0 - 24</td>
<td>Good Basic Nursing Care</td>
</tr>
<tr>
<td>Low Risk</td>
<td>25 - 50</td>
<td>Implement Standard Fall Prevention Interventions</td>
</tr>
<tr>
<td>High Risk</td>
<td>≥ 51</td>
<td>Implement High Risk Fall Prevention Interventions</td>
</tr>
</tbody>
</table>

---

### Morse Fall Scale

**www.hartfordign.org**

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falling; immediate or within 3 months</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 25</td>
<td></td>
</tr>
<tr>
<td>2. Secondary diagnosis</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 15</td>
<td></td>
</tr>
<tr>
<td>3. Ambulatory aid:</td>
<td>Bed rest/nurse assist 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crutch/cane/walker 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Furniture 30</td>
<td></td>
</tr>
<tr>
<td>4. IV/Heparin Lock</td>
<td>No 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 20</td>
<td></td>
</tr>
<tr>
<td>5. Gait/Transferring</td>
<td>Normal/bed rest/immobile 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weak 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impaired 20</td>
<td></td>
</tr>
<tr>
<td>6. Mental status</td>
<td>Oriented to own ability 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forgets 15</td>
<td></td>
</tr>
</tbody>
</table>

---

**Sample Risk Level**

*Sample Risk Level Sheet*
Strength of Physician Guidelines Rating Scale:

- **A** = Strong recommendation
- **B** = Recommended
- **C** = No recommendation +/- routine intervention
- **D** = Not recommended for asymptomatic patients
- **I** = Insufficient data for decision to be made +/-

**Note:** rating scale indicated in upper L corner of some slides

(AGS/BGS, 2010; Panel on Prevention, 2011)
Synopsis of AGS & BGS Clinical Practice Guideline’s Recommendations

• Multifactorial assessment & management of fall risk factors
  – A = Home environment modification/adaptation
  – A = Exercise: balance, strength, & gait training
  – B = ↓ total # of medication prescriptions or dosage of individual medications; all meds should be reviewed, minimized, or stop

(AGS/BGS, 2010; Panel on Prevention, 2011)

Synopsis of Clinical Practice Guidelines

• Multifactorial assessment & management of fall risk factors
  – C = Postural hypotension management; possible pacemaker
  – C = Foot problems & footwear management
  – C/D = Education could be one intervention strategy in a multifactorial fall prevention program
  – I/B/C/D = Vision

(AGS/BGS, 2010; Panel on Prevention, 2011)
Multifactorial Fall Risk Assessment

- **Medication review**
  - Prescribed
  - Over-the-counter
  - Transition of continuum of care

- **Vision**
  - Expedite cataract surgery
  - Multifocal glasses
  - Acuity
  - Contrast sensitivity
  - Depth perception

- **Focused fall history/Risks**
  - Frequency
  - Symptoms at time of fall
  - Injuries
  - Time of day
  - Activity when fall occurred

- (AGS/BGS, 2010; Panel on Prevention, 2011)

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Multifactorial Fall Risk Assessment

- **Physical Exam**
  - **Lower extremity function**
    - Gait and balance
    - Mobility levels
    - Strength
    - Sensation

- **Neurological exam**
  - Cognition
  - LE sensation
  - Proprioception
  - Reflexes
  - Cortical, extrapyramidal, & cerebellum

- **Cardiac**
  - Heart rate/rhythm
  - Postural pulse/blood pressure
  - Heart rate & blood pressure responses to carotid sinus stimulation

- (AGS/BGS, 2010; Panel on Prevention, 2011)
**MULTIFACTORIAL RISK FACTORS**

- Medical Impairments
  - Osteoporosis
  - Incontinence
  - Cardiovascular disease
  - Diabetes
  - Vertigo
  - Lower extremity weakness

---

**Multifactorial Fall Risk Assessment**

- Environmental assessment
  - “home” safety
  - Cognitive status

- Functional Assessment:
  - ADLS and IADLS
  - Self-efficacy: *Perceived functional ability & health*
  - Restricts activities older adult can perform, but chooses not to due to fear of falling
AGS and BGS (2010) Clinical Guidelines recommends for any adult with a fall history or other fall risk factors to:

- Have a home hazard assessment by an OT or qualified health professional to identify environmental home fall hazards [A]
- Receive home safety recommendations that may include modifications or removal of identified safety hazards [A]
- Follow-up after modifications and home safety recommendations have been given [A]
ENVIRONMENT

- Poorly used assistive walking device
- Uneven floor surfaces
- Slippery driveway
- Improper footwear
- Lack of handle bars in the bathroom
- Poor lighting
- Obstacle on stairs
- Monotone stair carpet or floor colouring
- Lack of railings on stairs
- Deep fluffy carpets
- Slippery bathtub
- Small scatter rugs
- Tree roots
- Sidewalk curbs, bumps and holes
- Dog walking

Good or Bad ??

continued
**Outdoors**

- Uneven surfaces
  - Cracks
  - Holes in yard
- Clutter
  - Porch
  - Yard
- Lighting
- Steps with/out handrails

**“Home” Safety for Those with Cognitive Deficits**

- Virtual Dementia Tour
- Consistency
- Structure
- Wandering
- Sundowning
- Sharps
- Personal safety device

- Safety
  - Fire
  - Phone usage
  - Vision
  - Dehydration
  - Pets
  - Driving

[www.alzstore.com](http://www.alzstore.com)
SAFER TOOL: Safety Assessment of Function and the Environment for Rehabilitation

- Living Situation
- Mobility
- Kitchen
- Fire Hazards
- Eating
- Household
- Dressing
- Grooming
- Bathroom and Toilet
- Medication
- Communication
- Wandering
- Memory Aids
- General

(Chiu, Oliver, Marshall, & Letts, 2001)
FUNCTIONAL ASSESSMENTS

Lawton ADL
- Ability to use telephone
- Shopping
- Food preparation
- Housekeeping
- Laundry
- Mode of transportation
- Responsibility to manage medications
- Ability to handle finances
(Lawton, & Brody, 1969)

Katz Index of IADLS
- Bathing
- Dressing
- Toileting
- Transferring
- Continence
- Feeding
(Katz, 1983)

Consider:
- Self-efficacy
- Habits
- Routines
- Interests

SNF: EVIDENCE-BASED FALL PREVENTION

Automatic W/C Braking System reduced falls by 78%

Individualized Continence Care reduced falls by 50%

Martorello & Swanson, 2006

(Klay & Marfyak, 2005)
AGS & BGS (2010) recommendation:

Balance and gait deficits should be assessed if older person has had a single fall to determine if person would benefit from a multifactorial fall risk assessment. [A]

**BALANCE AND GAIT**

**Recommended assessments [A]**

- Timed Get Up & Go
- 30 Second Chair Stand
- 4-Stage Balance
- Berg Balance Scale
- Performance-Oriented Mobility Assessment

(AGS/BGS, 2010; Panel on Prevention, 2011)
**MEDICATION GUIDELINES**

- Reduce total number of medications [B]
- Reduce or stop, taper PRN, psychoactive medications [B]
- Reduce, if possible, dosage of individual medications
- All medications should be: [B]
  - Reviewed
  - Minimized, PRN
  - Withdrawn, PRN

(AGS/BGS, 2010; Panel on Prevention, 2011)

---

**Medications Associated with Falls and Fractures**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Fall Risk</th>
<th>Fracture Risk</th>
<th>Hip Fracture Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedatives &amp; hypnotics</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholinesterase inhibitors</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>❌</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSAIDs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiepileptic</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticholinergics</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Nye, 2012; Van voast Moncada, L., 2011)
VITAMIN D

Significantly reduces fall rates (Gloyh, et al., 2014; Pitz, et al., 2011)

800-1000 IU per day in SNF those who are deficient (AGS/BGS, 2010; Panel on Prevention, 2011)

VISION

CONTINUED
VISION DEFICITS

- Currently, there is mixed research related to falls and vision [I]
- Insufficient evidence demonstrates vision assessment/intervention should be a single approach to fall prevention [D]
- Expedite cataract surgery among older women, PRN [B]
- Vision correction may increase fall risk due to adjusting to new glasses
- Multifocal lenses should not be worn while walking, particularly on stairs [C]

VISION AWARENESS TRAINING OF ENTIRE STAFF

- Compared to cost of 1 SNF resident’s fall; low cost in educating entire staff on vision
- Increases staff’s knowledge:
  - Visual impairments
  - Fall and fear of fall risk factors
  - Increases resident’s quality of life

(Leland, et al., 2012; Teresi, et al., 2013)
### Vision Recommendations

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Environmental Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visual Disorders</strong></td>
<td>Eye exams; ↓ glare; document annual exam</td>
</tr>
<tr>
<td><strong>Visual Monitoring</strong></td>
<td>Daily glasses; Use croakies; cleaned; adj.; worn; belongs to resident; approach person from front; needs repair?</td>
</tr>
<tr>
<td><strong>Multifocal?</strong></td>
<td>Stairs; Use sgl. lenses; handrails; assist PRN</td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td>• Lighting</td>
</tr>
<tr>
<td></td>
<td>• Contrast</td>
</tr>
<tr>
<td></td>
<td>• Depth</td>
</tr>
<tr>
<td></td>
<td>• Peripheral vision</td>
</tr>
<tr>
<td></td>
<td>• Central vision</td>
</tr>
</tbody>
</table>

(Leland, et al., 2012; Teresi, et al., 2013)

#### Visual Deficits

**Contrast Sensitivity**

- Ability to distinguish between subtle changes between light and dark

![Contrast Sensitivity Diagram](image-url)
MARS SENSITIVITY

- Each chart has 48 different contrast levels, declining gradually in 0.04 log unit steps
- Available in both letter and numeral versions
- Matte surface allows even lighting with no glare-inducing hot spots.
(Also Pelli Robson charts)

VISUAL DEFICIT

Depth Perception
- Ability to identify how much space there is between objects and/or how far away something is located
- Older adults are 10 X more likely to lose depth perception
Various Randot Stereotests

Frisby Stereopsis Test

Depth Perception Tests

FEET AND FOOTWEAR

Risk

AUGH!
PERIPHERAL NEUROMAL

CONTINUED™
ADDITIONAL FALL RISKS CONSIDERATIONS

- Syncope medical management
- Orthostatic hypotension
- Pacemaker
- Dizziness
- Vestibular rehabilitation needed?
- Epley Maneuver
- Hip Protectors
- Evidence does not support using them
- Bed alarms
- Have alarm go off only at nursing station

Fear of Falling (FOF)

“lasting concern about falling that can lead an individual to avoid activities that he/she remains capable of performing” (Tinetti, Richman, & Powell, 1990, p. 239)

“low perceived self-efficacy at avoiding falls during activities of daily living” (Tinetti, Richman, & Powell, 1990, p. 239)

Self-efficacy: a person’s self-perceptions and degree (level) of performing specific areas of occupations (AOTA, 2014)

Complex construct involving client factors including mental, sensory, and neuromuscular functions (AOTA, 2014)
"I’m not afraid... I just don’t do that anymore."

- Can occur in 50% + newly admitted SNF residents (Gillespie & Friedman, 2007)
- Hospitalized patients (68%)
- Increases risk for falls
- Leads to activity self-restriction in 30% of adults over 65 years of age
- Consider caregiver’s, caregiver and healthcare professionals, fear of falling in therapy compliance and fall risk

(Bolz, et al., 2014; Boyd & Stevens, 2008; Brannan, et al., 2012; Donoghue, Cronin, Savva, O’Reagan, & Kenny, 2013; Kumar, et al., 2014; Oh Park, et al., 2011; Painter, et al., 2012; Shen, et al., 2015)
**SNF Fear of Falling Risk Factors**

- Female gender
- Poly-pharmacy
- Fall history
- Fall-related injuries
- Age
- Balance
- Gait & mobility deficits
- Decreased ADL performance
- Activity restriction
- Social isolation
- Decreased quality of life
- Sedentary Lifestyle
- Depression
- Anxiety

(Oh-Park, et al., 2011; Painter, et al., 2012; Scheffer, et al., 2008)

**CareGiver’s FOF**

**Family vs. Healthcare Professionals**

- Family caregiver strain level and person with dementia baseline physical function are upon admission to hospital affect degree of caregiver anxiety (Boltz, et al., 2015)
  - Crucial to assess for successful transition to hospital and use multifactorial approach (Boltz, et al., 2015)
- Family Caregiver(s) of those with Dementia
  - Greater disparity between older person with hip fracture (in rehab) and caregiver’s FOF, greater negative impact on rehabilitation—used FES-I (Shen, et al., 2015)
CAREGIVER STRESS SCREENINGS

- Caregiver Self-Assessment Questionnaire
  (Epstein-Lubow, et al., 2010)
- Caregiver Strain Index (Brannan, et al., 2012)
- Caregiver Stress Check (www.alz.org)

CAREGIVER’S FOF
FAMILY VS. HEALTHCARE PROFESSIONALS

- Health caregiver's view if person with dementia is in pain or may fall
- Determines restraint/restriction usage
- Affects functional ability; deconditioning; activity restriction; QOL

(Fitzgerald, et al., 2009)
The higher the caregiver strain and the lower the baseline physical function of a person, with dementia, are at hospital admission, the higher the degree of caregiver anxiety.

- Crucial to assess for successful transition to hospital and use multifactorial approach
- Provide staff development fall prevention education and training
  - Mutuality Scale – relationship between caregiver and patient
  - Modified Caregiver Strain Index
  - HADS-A and HADS-D

(Boltz, et al., 2015)
**Falls Efficacy Scale International (English)**

If you have any questions about how concerned you are about the possibility of falling for each of the following activities, please check the box that best describes your concern. Please rate how concerned you are about the possibility of falling for each activity. Please try to think about how you really are in the activity. You cannot cheat on this; the activity is important. If you currently don’t do the activity, answer how you think you would be concerned about falling if you did the activity.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not at all concerned</th>
<th>Somewhat concerned</th>
<th>Fairly concerned</th>
<th>Very concerned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Walking indoors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Getting dressed or undressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Getting in or out of a chair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Getting up or down stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Reaching for something above your head or on the ground</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Walking up or down a slope</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Falls Efficacy Scale International**

- **Low Concern:** 16–19
- **Moderate Concern:** 20–27
- **High Concern:** 28–64

- Very good relative reliability (intra-class correlation 0.88) and internal consistency reliability (Cronbach's alpha 0.94) (Halvarsson, Franzén, & Ståhle, 2013)

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**Short Falls Efficacy Scale-International**

- **Low Concern:** 7-8
- **Moderate Concern:** 9-13
- **High Concern:** 14-28

- Excellent internal reliability Cronbach's alpha 0.92;
- Correlation between the Short FES-I and the FES-I is 0.97 (Kempen et al., 2008)

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**Short FES-I**

Now we would like to ask some questions about how concerned you are about the possibility of falling. Please reply thinking about how you usually do the activity. If you currently don’t do the activity, please answer how you think you would be concerned about falling if you did the activity. For each of the following activities, please circle the box which is closest to your opinion about how concerned you are that you might fall if you did this activity.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not at all concerned</th>
<th>Somewhat concerned</th>
<th>Fairly concerned</th>
<th>Very concerned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting dressed or undressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Taking a bath or shower</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Getting in or out of a chair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Getting up or down stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Reaching for something above your head or on the ground</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Walking up or down a slope</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Going out to a social event (e.g., religious service, family gathering or club meeting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Survey of Activities and Fear of Falling in the Elderly (SAFFE) (Lachman, et al., 1998)

Activities-Specific Confidence Scale (ABC) (Powell, L. E. & Myers, 1995)

Are there still missing pieces to the puzzle of falls prevention?
1. COGNITION

- AGS/BGS, 2010 recommendation
  - Insufficient evidence that supports any specific recommendations to reduce fall risk
- St. Louis University Mental Status (SLUMS)
- Montreal Cognitive Assessment (MOCA)
- Mini-mental State Examination

SLUMS

- Valid and reliable
- More sensitive identifying older adults with mild cognitive impairment compared to MMSE (Tariq, et al., 2006)
MOCA: Highly recommended to use with Stroke population - all settings (Toglia et al., 2011)

Scoring:
Mild Cognitive = 18-26
Moderate Cognitive = 10-17
Severe = < 10
Mild Alzheimer Disease = 11-21

http://www.mocatest.org/faq/
Depression
- Most prevalent older adult mental disorder (Pietrzak et al., 2013)

Anxiety
- Common in older adults and underdiagnosed (APA, 2013)
Depression & Anxiety Scales

Depression Scales
- Beck FastScreen for Medical Patients (Beck, et al., 2000)
- Geriatric Depression Scale (Long/Short) (Sheikh & Yesavage, 1986)
- Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960)
- Hospital Anxiety and Depression Scale (HADS-D) (Burton, et al., 2015; Zigmond & Snaith, & Tyson, 1983)

Anxiety Scales
- Generalized Anxiety Disorder-7 Item (GAD-7) (Robert, et al., 2006)
- Hamilton Rating Scale for Anxiety (HAM-A) (Hamilton, 1965)
- Hospital Anxiety and Depression Scale (HADS-A) (Burton, et al., 2015; Zigmond & Snaith, & Tyson, 1983)
BARRIERS TO IMPLEMENTATION

- Beliefs
- Knowledge
- Confidence
- Motivation
- Time
- Money
- Access
- Availability
- Affordability
- Perceived risk
- Belief of benefit(s)
- Physical & psychosocial function

- Cultural views & social changes
- National & insurance funding
- Resistance to social safety net programs
- Project implementation methods
- Level of support
- Sustainability
- Facility culture and traditions
- Fragmented Care
- Access to health professionals

- Social, Economic & Political
- SNF: Organization and Staff
- Residents
- Caregivers

(Allison, 2015)

Most Frequent Factors in Slip, Trip & Fall Incidents

- 16% Housekeeping Issues
- 25% Wet or Slippery Surfaces
- 14% Human Factors
- 1% Poor Lighting
- 2% Stairs
- 2% Ladders
CHANGING SNF FOCUS

- Cost of 2 hip fractures ~ $81,000
- Average salary of healthcare implementation specialist ~ $79,000
- Average salary of CNA ~$25,000

- Educate all staff
- Utilize evidence-based practice
- Participate in research
- Hire skilled healthcare implementation specialists & CNAs
- Need complete commitment to support front-line practice

(Allison, 2015)
FROM MULTIDISCIPLINARY TO INTERDISCIPLINARY EDUCATION

- Involves entire staff (healthcare, housekeeping, office and kitchen staff, groundkeepers, etc.)
- Involves communicating each resident’s change in condition
- Ensures no assumptions are made regarding who is accountable for each fall prevention component
- Have plan of action in place when fall does occur
  - How will next shift know the person fell; plan of care?
  - Educate staff of missing link(s) to falls and/or FOF

(Bonner, 2006)
POST-FALL PLANNING

- Crucial—teachable moment
- Invest and involve entire staff
  - Ask CNA “Can you give me 3 interventions we can do right now to reduce fall risks?”
- Consider resident’s habits and routines
- Post-fall huddle: Time, place, activity, BP, insulin, clothing, glasses, what and why it happened.
- Environmental rounds: teachable moment
- 4 P's Rounding

(OBSERVATION FOR THOSE WITH & WITHOUT DEMENTIA)

4 P’s Rounding

- What is your pain on scale of 1-10?
- Your comfort is important; what can I do to help?
- Are there any personal belongings you want closer to you?
- Do you need to go to the bathroom?

(Painter-Patton, SNF & Falls 2016)
IMPLEMENTATION
RESOURCES

Author/Editor: Rein Tideiksaar

EVIDENCE BASED
PROGRAMS

Stepping On
Building Confidence and Reducing Falls

A MATTER OF BALANCE
MANAGING CONCERNS ABOUT FALLS

Falls Free®:
2015 National Falls Prevention Action Plan
National Falls Prevention Resource Center

continued
Summary….

- Fall Prevention starts on first day of Admission
- **Become proactive**
  - Review the AGS/BGS Clinical Practice Fall Prevention Guidelines
  - Review the STEADI resources and assessments
  - Determine how the Clinical Practice Fall Prevention Guidelines and STEADI may be implemented within your practice area
  - Review the Falls Free®: 2015 National Falls Prevention Action Plan

SUMMARY CONTINUED

- **Be Proactive**
  - Take the lead in addressing and developing an efficacious falls prevention and fear of falling program within your SNF practice and community
  - Consider caregiver
  - Identify fall risks
  - Educate yourself and colleagues on evidence-based falls prevention programs
  - Join your State’s and your local Fall Prevention Coalition
ARE YOU NOW READY TO STEP UP TO STOP FALLS?

Leaves are supposed to fall. People aren't.

pattonja@ecu.edu
REFERENCES


REFERENCES


Nye, A. (2012). Preventing Medication-related Falls. Presentation, Sept. at ECU Heart Institute, Greenville, NC.


REFERENCES


