An Individualized Fall Prevention Program fore Older Adults: Partnerships in Practice

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Purpose

- Identify risk factors for older adults related to falls at home.
- Support older adults seniors in independence and prevent premature institutionalization
- Schedule home visits using the researcher designed *Falls Risk Assessment Tool, the Romberg Assessment Test, and Get-Up and Go Test* at home visits
- Follow-up on educational and safety needs for at –risk seniors with referrals.

Description of Seniors in Case Management

- Multiple chronic conditions
- Frail
- Homebound
- Socially Isolated
- Low income as compared to community (average income for >60 is $72,000- $198,260)

Very Low 0-30% < $22,300	Very Low 31-50% $22,300-37,150	Low 51-80% $59,400-88,600	Moderate 80% - up $88,600 >
90%	8%	2%	0

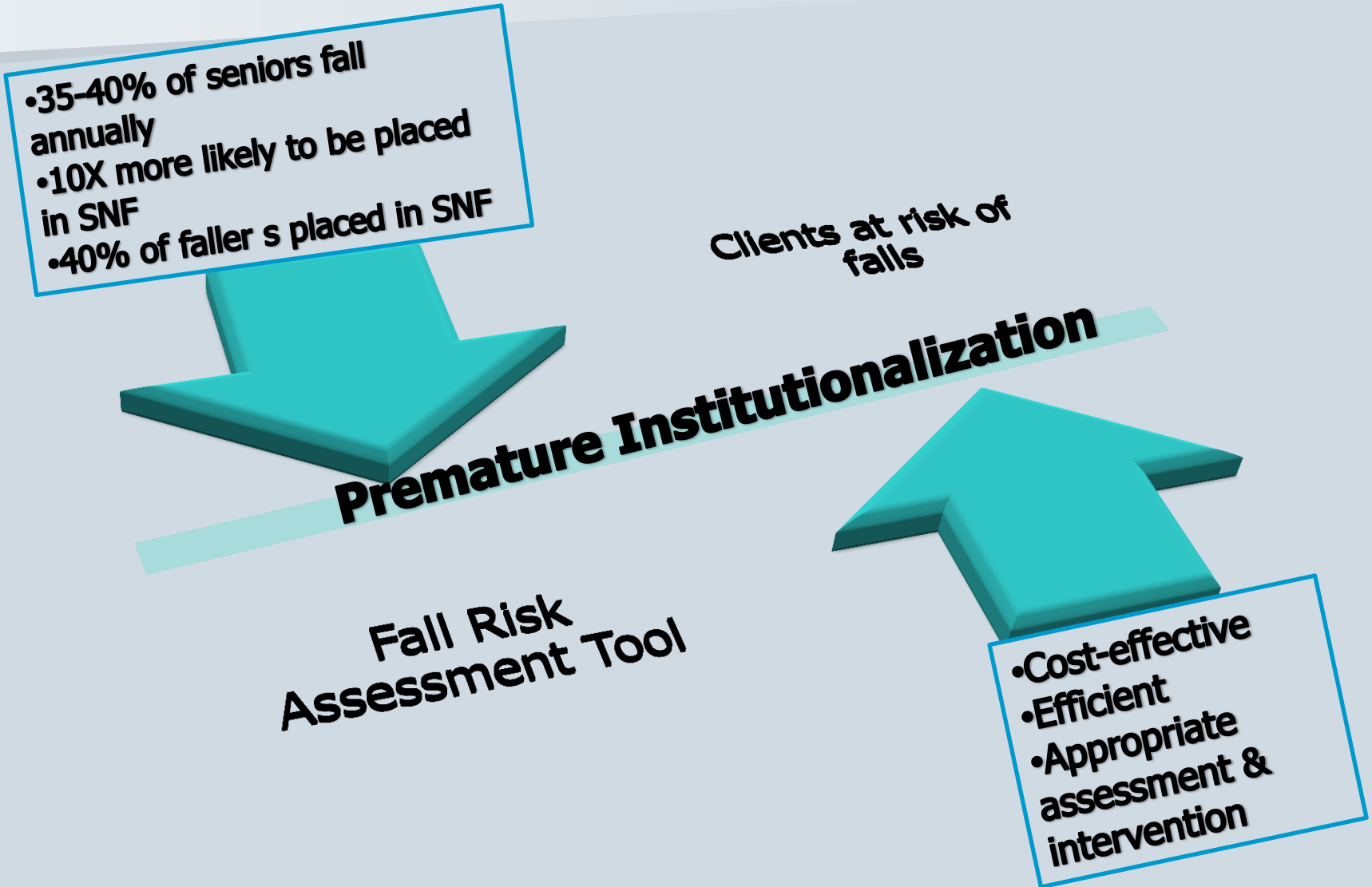
Factors Related to Falls

- Extrinsic Factors
  - Weather
  - Home environment
  - Lighting
  - Use of adaptive devices
  - Footwear/clothing
- Intrinsic Factors
  - History of falls
  - Chronic diseases
  - Medical conditions
  - Sensory impairments
  - Medications
  - Level of functioning

Assessment of Older Adults at Risk for Falls

Prior History	**Balance and gait disturbances**	**Use of assistive devices**
Impaired Vision	**Four or more medications**	**Stairs**
Incontinence	**Dependence is transferring**	**Loose rugs**
Lower extremity weakness	**ADL dependence**	**Poor lighting**

Development of the Falls Risk Assessment Tool



Research Design

- **Convenience Sample** of older adults in a community agency—senior case management that were identified as high-risk for falls.
- **Falls Risk Assessment Tool-**designed and implemented for pilot with recommendations
- **Follow-up-**2 years in resulting three phases resulting in decreased falls in older adults and safety in the home.

Community Partners

Phase 1

- Clinical Instructor, 2 Senior Nursing Students, and Social Work Intern collaborated on need of an assessment tool for senior case management at this community agency.
- Review of evidenced based research supporting assessment and prevention

Community Partners

Phase 1 (Continued)

- Review of **145 senior case charts** for fall factors with: 285 falls risk factors
- **3 Highest Ranked Risk Factors**:
  - Four of more medications (84 indicators)
  - Use of Assistive Devices (81 indicators)
  - Impaired Vision (40 indicators)
- Development of the standardized tool: *Falls Risk Assessment Tool*.

Fall Risk Assessment Tool[1]			
Client Name:		*Age:*	*Date:*
Area	**RISK FACTORS**		Mark all that apply:
Prior Fall	**History of Falls[2]:** client has fallen once in the last year.		
	History of Recurrent Falls: client has fallen 2 or more times in the last year (2 points)		
	History of Injury Related to Fall: a fall within the last years has resulted in injury.[3]		
	History of Hospitalization Related to Fall: a fall within the last years that has resulted in hospitalization.		
	Fear of Falling: Does patient have a fear of falling?		
	Environmental Hazards: Structural barriers, safety hazards, clutter.		
Mobility	**Decreased independence in ADL's** (needs assistance with one or more ADLs--as indicated in the ADLs assessment)		
	Decreased independence in IADL's (needs assistance with one or more IADLs--as indicated in the IADLs assessment)		
	Decreased lower extemity strength: Client is unable to come to standing without the use of arms or has a history of LE weakness i.e. CVA or paralysis.		
	Limitations in lower extremity Range of Motion: Client indicates stiffness or problems with joints i.e. hips, knees, ankles, or has his		
	Balance: Ability to maintain balance without support for 30 seconds, history of dizziness, sensation of spinning, frequent loss of balance. If yes, nurse to do a balance check.		
	Use of Assistive Devices: Requires use of assistive devices for mobility including wheelchair, walker, cane, or prothesis		
	Mental Status/Behavioral Issues: Decreased cognitive function, level of alertness, comprehension, confusion		
Elimination	**Urinary incontinence**		
	Bowel incontinence		
Vision	**Does client have decreased vision from the last assessment?**		
	Does client use corrective lenses?		
	Partial or severe impairment of vision, disease related; glaucoma, cataracts, blindness, macular degeneration, etc...		
Medications	**Medications:** Currently taking 4 medications or more		
	2 or more of the following: *Sedatives/hypnotics, antihypertensives (blood pressure), diuretics (water pill), narcotics (pain relief), electrolyte-hormonal replacement for osteoarthritis or osteoporosis, (see Medication List)*		
		Total number of risk factors	

Mild: 1-7 risk factors
Moderate Risk: 8-14 risk factors
High Risk: > 15 risk factors

[1]Tool adapted by the University of Francisco School of Nursing, Community and Mental Health Clinical, from the Vanderbilt University Medical Center *Fall Risk Assessment Tool* by Patricia Fleming, PT, DSc. (GCS Pending approval) and *Christiana Care VNA Fall Risk Asessment Tool, New Castle, Delaware* for the Community Services Agency, Mountain View (approval on 4-14-08; modified 2-4-09 and 9-10-10).

[2] A fall is defined as any event that led to an unplanned, unexpected contact with a supporting surface.

[3] Injury in defined as any fracture or soft tissue injury requiring medical attention or resulting in activity restriction >48 hours.

Community Partners

Phase 2

- ***Fall Risk Assessment Tool*** was piloted with 25 at-risk older adults in Senior Case Management

Community Partners

Phase 2 (Continued)

- **7 Senior clients** scored at greatest risk of falls scoring between 12-17 (total number of risk factors) with no available resources.
  - These 7 were given a subscription to Stanford Life-Line for a year (supported by *Home Instead Senior Care*)
- **6 Seniors clients** scored between 7-15 but they were already using an emergency monitoring system and assuming the cost for the program *(Care -Call System).*
- **8 Senior clients** scored from 7-11 that would be continued to be monitored for six months or earlier as needed.
- **4 Senior clients**—moved out of the area, entered a skilled care facility, or died prior to the six month assessment.

Community Partners

Phase 3

- Home Visits completed on **21** identified at risk senior at scheduled home visits using the Falls Risk Assessment Tool:
  - **8 clients**—decreased risk factors
  - **5 clients** had increased risk factors
  - **3 clients** remained the same on their

Implications for Practice

- Education on risk factors (injury, disability, and death due to falls).
- Community partnerships (referrals to Falls Prevention Programs, physical therapy for balance training, exercise programs, use of home monitoring systems, and follow-up with physician on medications).
- Support for ongoing assessment with health professionals to prevent falls, decrease hospitalization, and costs to providers.

Conclusion

- **Community Innovation in Practice**: Results of this project and model to be presented in community to benefit a falls prevention program.

- **Ongoing Knowledge of Resources:** Health insurance may not cover all interventions for falls prevention.