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# Fall Risk Screening with Interventions for the Elderly

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**Manuscript****Practice Improvement Project: Fall Risk Screening with Interventions for the Elderly**

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## SUMMARY

**Background:** Falls are an important safety concern among the elderly. A practice change project to decrease falls in the elderly population was implemented in a Patient-Centered Medical Home (PCMH) setting in Oregon with the purpose to determine whether staff was satisfied with the change effort. This endeavor encompassed two other clinics in a broader system which also embraced the change initiative.

**Methods:** An electronic survey was offered to staff over a two week period to assess their satisfaction with the implementation of the tools used to screen the elderly for falls with those at risk receiving appropriate interventions. The Hendrich II was chosen to determine fall risk; the Falls Prevention Action Guide for Providers (FPAGFP) guided implementations for those susceptible to falls. The University of Portland (UP) institutional review board (IRB) approved this project.

**Results:** Of the 20 respondents who completed the surveys, 14 were providers and residents, and 6 were MAs. All staff valued assessing the elderly for fall risk in clinical practice. All but one of the MAs indicated it was easy/very easy to incorporate use of the Hendrich II into their workflow. The majority of the providers indicated the tools were beneficial to help reduce falls in the elderly. No correlation existed between providers who believed in the effectiveness of the use of the FPAGFP to guide their actions to reduce falls and the belief that using the tool took time away from the patient encounter.

**Conclusion:** This practice change project was beneficial in that it identified the majority of elderly at risk for falling and provided strategies for providers to choose to reduce the risk. Analyzing survey results for change endeavors is a helpful step to determine if there are apparent trends in responses. Focused group discussions may aid in the identification of reasons for suboptimal screening and implementation practices with direction provided for ways to improve them. Providers and MAs who are using the tools effectively could be mentors for those who are struggling to implement them into their daily practice.

### 1. Introduction

Falls are at the forefront for causing injury, disability and even death among those patients who are elderly. Approximately 700,000 to one million people fall every year in the United States (AHRQ, 2013). On an individual basis, one out of every three people ages 65 or older falls annually (Boye et al., 2012). Serious injury is the result of falling in **five** to 10 % of cases. Long-term outcomes of falling may have a significant effect on quality of life, including loss of independence, fear of falling, and disability (Gates, Smith, Fisher and Lamb, 2008). A fall is defined as "a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force" (CMS, 2011, p. 340).

Clinicians are often unaware of the existence of fall risk tools and are uncertain about which tool would be an appropriate choice for their setting and client population. Generally these tools are classified into three domains: 1) comprehensive medical assessment 2) nursing fall risk assessment and 3) functional mobility assessment. A properly chosen fall risk screening tool is invaluable as a first step in preventing falls (Perell, 2002). A systematic review of 29 screening instruments to predict fall risk among independently living elders was conducted by Gates et al. (2008). The American Geriatric Society/British Geriatric Society recommends the administration of a screening algorithm for the elderly which includes a timed performance test and a question about falls in the past year. Those found to be at high risk for falling would receive a more intense assessment with interventions. A plethora of fall risk screening instruments are available, ranging in complexity from one clinical test to those involving assessments of 10 or more. They also can be used in a variety of populations including the elderly in both the community and hospital, and adults in long-term care. Falls are predicted based on the timescale needed: days or weeks in the hospital setting compared to a year for those living in the community. "Tools developed for one population may therefore be less accurate when used in a different setting" (Gates et al., 2008, p. 1106). Typically the screening tests indicated higher specificity than sensitivity, meaning they correctly identified a higher number of non-fallers as compared to fallers. The most common use of fall tests included an initial screen of all elderly to determine those at high risk who warrant further assessment (Gates et al., 2008). Commonly used community based tools are: Falls Risk for Older People in the Community (FROP-COM) Screen, Tinetti gait, balance, or mobility scales (Performance Oriented Mobility Assessment or POMA), Timed Up and Go Test (TUG), and Falls Risk Assessment Score for the Elderly (FRASE). No one tool was found to be more sensitive for fall screening in the elderly and evidence suggests that a positive fall history and repeated abnormalities in balance or gait are the best predictors of falls.

## **2. Methods**

A practice change project to decrease falls in the elderly population was implemented in a Patient-Centered Medical Home (PCMH) setting in Oregon with the purpose to determine whether staff was satisfied with the change effort. This endeavor encompassed two other clinics in a broader system which also embraced the change initiative. An ad hoc committee was assembled to address the practice change, composed of a family practice physician, two Operation Project Managers, a Physical Therapist (PT), and RN Care Coordinators representing the three clinics involved. One of the clinics was chosen to study staff satisfaction with practice change efforts. At the ad hoc committee meeting the PT shared the Henrich II tool which was believed to be comparable to the tool they were currently trialing (Tinetti Balance) to assess for fall risk. An advanced literature search found numerous articles outlining the Hendrich II fall risk tool. This model had been used in the hospital environment: 'acute care' hospital setting or 'inpatients'. None referred to its use in medical clinics. Therefore there are no established reliability or validity measures associated with its use in the community setting. The decision

was made by the ad hoc committee to pilot the Hendrich II as a tool to screen fall risk for the targeted group for those 65 and older. It was determined that two additional questions would be added at the beginning of the Hendrich II tool, which assessed patient history and concern for falls: 1) Have you fallen in the last six months? (If yes, please list how many times). 2) Do you feel unsteady when you stand or walk, or have concern that you may fall at times? “The best predictors [of falls] appear to be a history of falls and abnormalities of gait or balance” (Gates et al., 2008, p. 1106). The Hendrich II Fall Risk Model is included in Appendix A.

The ad hoc committee decided that the Falls Prevention Action Guide for Providers (FPAGFP – Appendix B) was an appropriate tool to use to guide interventions for those at risk for falling, based on a previous presentation given by the Oregon Health and Science University (OHSU) Geriatric Assessment Unit staff. Team-based interventions to decrease falls were based on a model known as ‘Stopping Elderly Accidents, Deaths, and Injury’ (STEADI). Implementations were listed in order of fall causation. Since there are no reliability or validity measures associated with its use in combination with the Hendrich II, using these was designed to be a pilot project. The University of Portland (UP) institutional review board (IRB) approved this project.

### **3. Results**

A theoretical model called the knowledge translation framework or Knowledge to Action (KTA) model described by the Canadian Institutes of Health Research (CIHR) was chosen to guide the implementation of this practice improvement project (Licskai, Sands, Ong, Paolatto and Nicoletti, 2012). It was piloted over a two week period with minor changes made by the ad hoc committee as indicated. The practice change was then implemented in all the clinics in the broader healthcare system. An electronic survey was offered to staff in the PCMH over a two week period to assess their satisfaction with the implementation of the tools used to screen the elderly for falls with those at risk receiving appropriate interventions. See Appendix C for the survey used for the response of the providers and MAs to the practice change.

#### ***3.1 Importance of fall assessment in the elderly according to clinic staff***

The overall response of the clinic staff to the question asking the importance of assessing falls in the elderly in clinical practice ranged from 21% indicating it was *somewhat important* to 32 % reporting it was *important* and 47% as *very important*. None reported that assessing the elderly for falls was *not important*. See Figure 1.

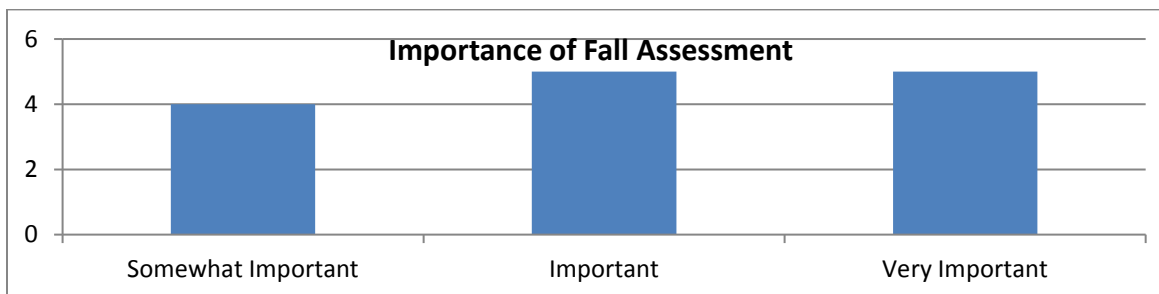


Figure 1. Importance of assessing falls in the elderly in clinical practice

### 3.2 Response of MAs using the Hendrich II

*Belief in FPAGFP, frequency of checking armband, competence in use of tool and ease of use*

Half (50%) of the respondents believed it was *important* and the other half (50%) believed it was *very important* to screen the elderly for risk of falling. For those who rated the importance of screening the elderly for risk of falling as *very important*, 2/3 (67%) reported they *always* checked the patient's age to determine if the risk assessment was needed, they felt *competent* using the tool, felt *competent* or *highly competent* asking questions/observing the 'Get-Up-and-Go Test: Rising from a Chair' on the Hendrich II risk assessment and that it was *easy* to incorporate the tool into their work flow. The 1/3 (33%) *occasionally* checked the patient's age to determine if the risk assessment was needed, felt *somewhat competent* using the tool, *felt competent* asking questions/observing the 'Get-Up-and-Go Test: Rising from a Chair' on the Hendrich II risk assessment and that it was *difficult* to incorporate the tool into the work flow.

For those who rated the importance of screening the elderly for risk of falling as *important*, 2/3 (67%) reported they *frequently* checked the patient's age to determine if the risk assessment was needed. One was *competent* and another *highly competent* using the tool, felt *competent* or *highly competent* asking questions/observing the 'Get-Up-and-Go Test: Rising from a Chair' on the Hendrich II risk assessment and that it was *easy* or *very easy* to incorporate the tool into their work flow. The 1/3 (33%) *occasionally* checked the patient's age to determine if the risk assessment was needed, was *competent* using the tool, was *competent* asking questions/observing the 'Get-Up-and-Go Test: Rising from a Chair' on the Hendrich II risk assessment and that it was *very easy* to incorporate the tool into the work flow. See Figure 2 for a comparison of frequency of checking age between the two groups.

### Importance of Fall Risk Screening:

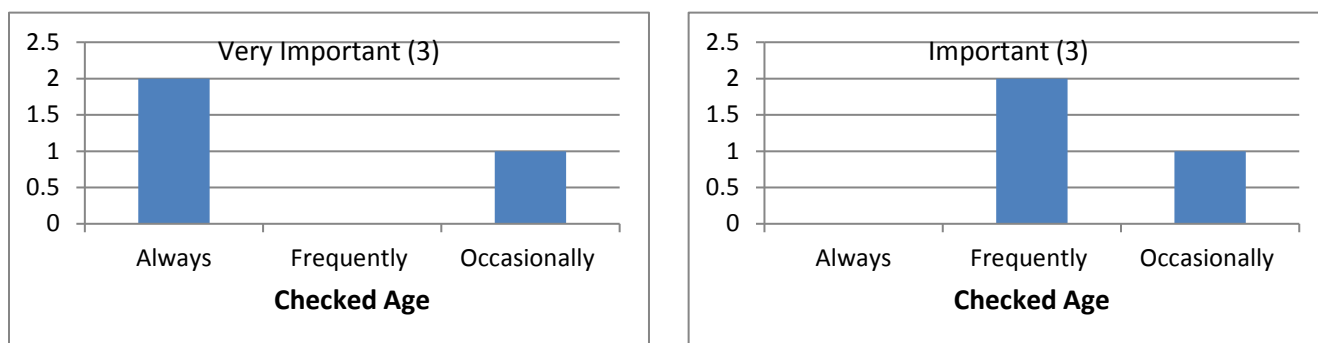


Figure 2: Frequency of checking age to determine if fall risk is needed

### 3.3 Response of Providers using the FPAGFP

#### *Effectiveness of FPAGFP and competence with use*

The majority of providers (7/13 or 54%) were *uncertain* how the FPAGFP compared to other tools to implement fall risk strategies for the elderly. Fifteen percent (2/13) indicated it was a *superior* tool; 31% (4/13) indicated it was *similar* to other tools. Greater than half (7/13) of the respondents were *uncertain* and one did not comment. None rated it as inferior. Fifty-four percent (7/13) reported feeling *somewhat competent* using the tool, 21% (3/13) were *not competent*, 8% (1/13) was *highly competent* and one did not comment.

#### *Providers who took 1 -2 minutes to complete FPAGFP, ease of use of tool, perceived competence and time away from visit*

Thirty-one percent (4/13) took 1 -2 minutes to use the FPAGFP. They rated themselves with varying levels of competence: one (8%) was *not competent*, two (15%) were *somewhat competent* and one (8%) was *competent*. The one individual rated as *not competent* indicated the tool was *easy* to use. This provider was also one of the three who believed the tool was *ineffective* in guiding actions to reduce falls. The two *somewhat competent* individuals rated the tool as *easy/difficult* and the *competent* person rated the tool as *easy*. The provider who indicated the FPAGFP was *difficult* to use indicated feeling *somewhat competent* using it. One of them *agreed* and one *strongly agreed* that it took time away from their visit (the one who *strongly agreed* also indicated it was not a helpful tool to reduce falls). The one who *agreed* did not answer whether the FPAGFP was an effective tool to reduce falls. The other two *disagreed* that it took time away from their visit.

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*Providers who took 3 - 5 minutes to complete FPAGFP, ease of use of tool, perceived competence and time away from visit*

Nine providers (69%) took 3 – 5 minutes to use the FPAGFP and one did not comment. Four of eight respondents (50 %) *agreed* and one (13 %) *strongly agreed* that using the tool took time away from the patient visit. Twenty-five percent (2/8) *disagreed* and 13% (1/8) *strongly disagreed* that it took time away from the patient visit. The person who *strongly disagreed* reported the FPAGFP was *very important* in guiding implementations for falls. Those who *disagreed/strongly disagreed* that using the FPAGFP took time away from their visit believed the tools were *effective* to guide implementations for falls. One (13 %) indicated feeling *highly competent*, one (13 %) was *competent* and the remainder were *somewhat competent* (5/8 or 63%) or *not competent* (1/8 or 13%) using the tool. One did not respond to this question. The three *highly competent/competent* individuals rated the tool as *easy* to use, three of the five (60%) *somewhat competent* people rated the tool as *difficult* and two of the five (40%) rated it as *easy*.

*3 providers disagreed that tools will reduce falls*

One individual rated fall assessment as *very important, strongly agreed* that using the FPAGFP took time away from the patient visit and *disagreed* that using both tools would help to reduce falls in the elderly. This person *took 3 – 5 minutes* to use the FPAGFP. Another individual who *disagreed* that both tools will help to reduce falls indicated that it was *important* to assess for falls in the elderly, and left many of the survey questions unanswered. This provider also indicated being *uncertain* about how the FPAGFP compared to other tools and rated *not competent* in its use. The third individual who *disagreed* that both tools were effective in reducing falls also indicated the FPAGFP was *ineffective* in guiding actions to reduce falls and *strongly agreed* that using the tool took time away from the patient visit. This person took *1 - 2 minutes* to use the FPAGFP.

*Use of the FPAGFP took time away from the patient visit (7/12)*

As previously noted, two respondents (2/12 or 17%) *strongly agreed* that using the FPAGFP took time away from their patient visit (one rated *1 -2 minutes* and the other *3 – 5 minutes* to use the tool). Forty-two percent (5/12) *agreed* that using the FPAGFP took time away from their patient visit (one rated *1 – 2 minutes* and four rated *3 -5 minutes* to use the tool). More than half of all respondents (7/12 or 58%) indicated that using the FPAGFP took time away from the patient visit. Thirty-three percent (4/12) of them *agreed* the tools helped to reduce falls; the other did not comment (the one who took *1 -2 minutes* to use the tool). The two respondents who *strongly agreed* that using the tool took time away from the visit both *disagreed* that the use of both tools were helpful in reducing falls. The third person who



*disagreed* that using both tools reduced falls did not comment whether the use of the FPAGFP took time away from the visit.

*Use of the FPAGFP did not take time away from the patient visit (5/12)*

Thirty-three percent (4/12) *disagreed* the FPAGFP took time away from their patient visit. Half of them took *1 - 2 minutes* to use the tool while the other half took *3 – 5 minutes*. --% (1/12) *strongly disagreed* the FPAGFP took time away from their patient visit took *3-5 minutes* to complete the tool and believed it was *very important* to assess for fall risk in the elderly population. Eighty percent (4/5) of them indicated they believed the FPAGFP was *effective* to guide their actions to reduce falls; one (20%) rated it as *ineffective*.

*Time to use tools, ease of tool use and perceived competence*

The 4 providers who took *1 - 2 minutes* to complete the tool rated themselves with varying levels of competence: one was *not competent*, two were *somewhat competent* and one was *competent*. The one individual who was rated as *not competent* indicated the tool was *easy* to use. The two *somewhat competent* individuals rated the tool as *easy/difficult* and the competent individual rated the tool as *easy*. Nine providers took *3 – 5 minutes* to use the FPAGFP and one did not comment. For these individuals, one (11%) was *highly competent*, one (11%) was *competent*, 5 (56%) were *somewhat competent*, one (11%) was *not competent* and one did not respond. The three *highly competent/competent* individuals rated the tool as *easy* to use, three of the five (60%) *somewhat competent* people rated the tool as *difficult* and two of the five (40%) rated it as *easy*.

*Effectiveness of FPAGFP in guiding actions to reduce falls and time away from visit*

Nine of 12 respondents (75%) *agreed* that using the FPAGFP guided their actions to reduce falls. Three of them (33%) *agreed* and one (11%) *strongly agreed* that using the tool took time away from their patient visit for a total of 44%. Three of the nine (33%) *disagreed* that time was taken away from the visit when using the tool and one (11%) *strongly disagreed*. One participant did not answer the question. See ...

The remainder of the respondents (3/12 – 25%) indicated that using the FPAGFP was *not effective* to guide their actions to reduce falls. One *agreed* (33%), one *strongly agreed* (33%) and one *disagreed* (33%) that using the tool took time away from the visit. See...

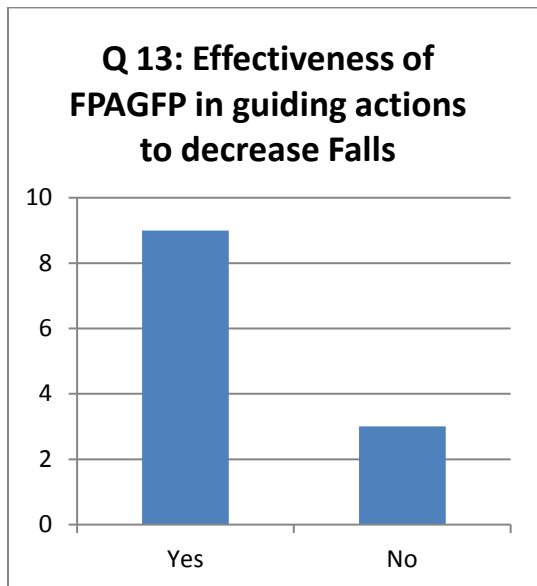


Figure 3: Effectiveness of FPAGFP in guiding actions to decrease falls

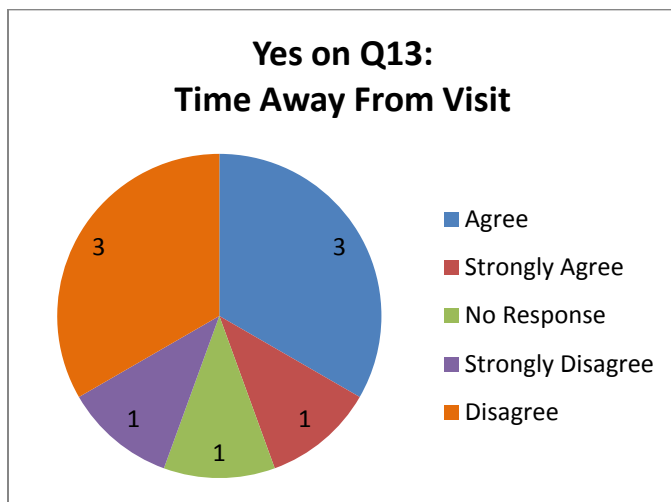


Figure 4: Those providers who believe the FPAGFP is effective in guiding actions to reduce falls rate whether using the tool takes away from the visit

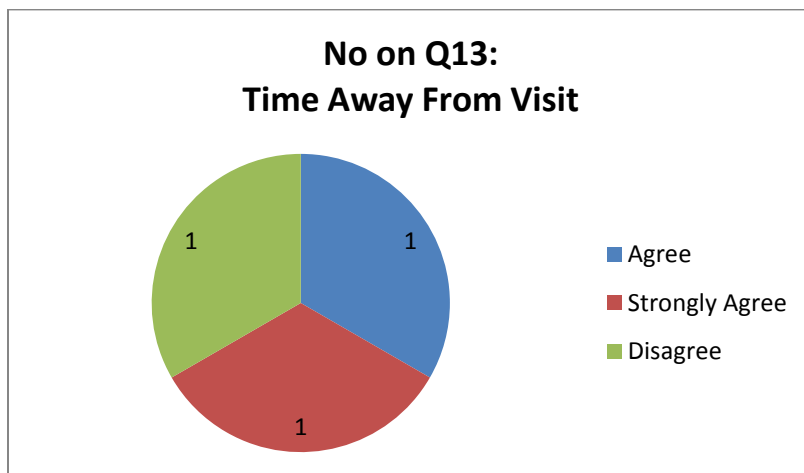


Figure 5: Those providers who believe the FPAGFP is not effective in guiding actions to reduce falls rate whether using the tool takes away from the visit

#### 4. Discussion

##### *Overall clinic response*

All staff agree that assessing the elderly for falls is important, with variations in the intensity of the response. None disagree that it is not important. A necessary first step when implementing practice change is to make the determination that it is valued by the staff.

##### *MAs*

Differences are noted between the two groups of MAs who rate the importance of screening for falls as very important versus important. Two of the three who rate the choice as very important indicate they always check the patient's age to determine if the risk assessment is needed while one occasionally checks age. For those who rate the importance of screening the elderly for risk of falling as important, 2/3 report they frequently check the patient's age to determine if the risk assessment is needed. The other respondent occasionally checks age.

Determining the patient to be 65 or over is a crucial step; without this information it cannot be determined whether 1) a fall risk assessment is needed and 2) if the patient is at risk for falling. To improve checking the patient's age from frequently to always, attitudinal changes may need to occur for the MAs to believe that screening the elderly for falls is very important as compared to important. Interestingly the one MA who rates screening for falls as important occasionally checks the age of the patient, is competent using the tool and finds it very easy to incorporate the tool into the work flow. More information needs to be gained from this individual to determine why there is an inconsistency in identifying those at risk for falling. The

MA who indicates feeling somewhat competent using the tool but has difficulty incorporating it into the work flow needs further consideration to understand underlying factors.

### *Providers*

The majority of providers are unsure how the use of the FPAGFP compares to other useful tools to guide implementations for the elderly at risk for falling. It may be important to consult with them regarding their need for exposure to available tools and importance of their input into choosing the best tool for their clinic. This may encourage an ownership of the practice change with increased motivation for its successful implementation.

There is not a direct correlation between time of tool completion, perceived level of competence, and ease of use of the FPAGFP for those who took 1 -2 minutes to complete the tool. For those who use 3 -5 minutes of time, more than half consider themselves somewhat competent in its use. The others vary in their responses. It may be assumed that improving training with the use of the tool will enhance level of competence and decrease time for using it.

The question which asks about the time it takes for providers to complete the FPAGFP measures attitude towards its effectiveness. Although using the tool takes just 1 - 2 minutes for some individuals, those who agreed that it takes time away from their visit either indicate it is not helpful to reduce falls or did not comment. The ones who indicate it does not take time away from their visit vary in their responses to tool effectiveness. Seventy-five percent of providers who take 1 – 2 minutes to complete the tool believe it is not effective to guide them to reduce falls. Perhaps those providers who take less time to complete the FPAGFP and view it as helpful can be mentors for those who take longer. Two of the 14 respondents who voice strong agreement that using the FPAGFP takes time away from their patient visit both indicate they disagree that using the tools would reduce falls. One took 1 – 2 minutes to use the FPAGFP while the other took 3 – 5 minutes. The third provider did not respond to these questions. It may be inferred these providers feel frustration with the practice change. A focused discussion group may be helpful to resolve their concerns.

The majority of the respondents take 3 -5 minutes to complete the FPAGFP; more than half agree/strongly agree (5) that using the FPAGFP takes time away from their patient visit. For the providers taking 1 – 2 minutes to complete it, half of them agree/strongly agree that using the tool took time away from the patient visit. The vast majority of them believe the tools are helpful to reduce falls. These individuals may feel time pressured during their clinic visit. Of the one third of providers who disagree the FPAGFP takes time away from their patient visit, equal variance is noted in their completion time. Interestingly they all agree in the effectiveness of the tool to reduce falls. This question may measure time perception as opposed to actual time or the provider's ability to use time efficiently during the office visit. Two strongly agree and one does not comment that using the tool takes time away from their visit. One of these takes 1-2 minutes

while the other takes 3 – 5 minutes to complete the FPAGFP. This suggests these providers do not believe the time it takes them to complete the tool is well spent.

An important question to consider is whether providers agree that using the FPAGFP will guide actions to reduce falls in the elderly. No correlation exists between providers who believe in the effectiveness of the use of the FPAGFP to guide their actions to reduce falls and the belief that using the tool takes time away from the visit. A myriad of factors are inherent in the perception of the efficient use of time during the patient visit: actual length of the visit, complexity of patient, provider personality, value of the tool, and perceived competence in using it to list but a few. A focus discussed group is needed to determine the various elements of provider performance that are most beneficial during the patient visit.

## **5. Conclusion**

Analyzing survey results for practice change is a helpful step to determine if there are apparent trends in responses. This strategy can identify work practices that may result from individual values, perceived competence in using clinical tools, and beliefs that actions based on these tools will make a difference in outcome. To ensure a successful practice change, it is beneficial to identify who completed the surveys without fear of reprisal. Individual discussion with employees may help to understand reasons for suboptimal screening and implementation practices, providing direction for ways to improve them. Focus discussion groups is another avenue to facilitate discussions among staff to promote successful change endeavors.

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**Appendix A**

## Hendrich II Fall Risk Model (two additional questions added at top)

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Review with patient each section.

	YES	NO
Have you fallen in the last six months? (If yes, please list how many times)		
Do you feel unsteady when you stand or walk, or have concern that you may fall at times?		

<b>Hendrich II Fall Risk Model</b>
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RISK FACTOR	RISK POINTS
Confusion/Disorientation/Impulsivity	4
Symptomatic Depression	2
Altered Elimination	1
Dizziness/Vertigo	1
Gender (Male)	1
Any Administered Antiepileptics (Anticonvulsants): (Carbamazepine, Divalproex sodium, Ethotoin, Ethosuximide, Felbamate, Fosphenytoin, Gabapentin, Lamotrigine, Mephenytoin, Methsuximide, Phenobarbital, Phenytoin, Primidone, Topiramate, Trimethadione, Valproic Acid) <sup>1</sup>	2
Any Administered Benzodiazepines: <sup>2</sup> (Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Dipotassium, Diazepam, Flurazepam, Halazepam <sup>3</sup> , Lorazepam, Midazolam, Oxazepam, Temazepam, Triazolam)	1

## PRACTICE IMPROVEMENT PROJECT: FALL RISK SCREENING WITH INTERVENTIONS FOR THE ELDERLY

Get-Up-and-Go Test: "Rising from a Chair" If unable to assess, monitor for change in activity level, assess other risk factors, document both on patient chart with date and time.	
Ability to rise in single movement - No loss of balance with steps	0
Pushes up, successful in one attempt	1
Multiple attempts but successful	3
Unable to rise without assistance during test. If unable to assess, document this on the patient chart with the date and time.	4
<b>(A score of 5 or greater = High Risk)</b>	<b>TOTAL SCORE</b>
Source: The Hardford Institute for Geriatric Nursing, New York University, College of Nursing.	

## On-going Medication Review Updates:

1. Levetiracetam (Keppra) was not assessed during the original research conducted to create the Hendrich Fall Risk Model. As an antiepileptic, levetiracetam does have a side effect of somnolence and dizziness which contributes to its fall risk and should be scored (effective June 2010).
2. The study did not include the effect of benzodiazepine-like drugs since they were not on the market at the time. However, due to their similarity in drug structure, mechanism of action and drug effects, they should also be scored (effective January 2010).
3. Halazepam was included in the study but is no longer available in the United States (effective June 2010).



## Appendix B

# Falls Prevention Action Guide for Providers

**Medication changes** related to decreasing fall risk:

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**Community exercise programs** (see handouts for resources and contact information ex: **Sam Fit Tai Chi**).

**Home safety inspection** to evaluate the need for any modifications (**Referral to Home Health**. Home bound only to qualify Home Health). Give pt **Check for Safety brochure**.

**Vitamin D** daily.

**Community exercise programs, Strength/balance exercises** (for resources and contact information online ex: **Sam Fit, Balance Training**).

**Physical therapy** for balance/gait. "A referral has been started and you will be contacted to schedule an appointment." Provider please use **719.7** difficulties in walking, **781.2** abnormality of gait, **781.3** lack of coordination, **728.87** generalized weakness. For tracking purposes.

**Begin use of assistive device:** \_\_\_\_\_ to help with stability while walking Have an eye examination. Refer if needed. "A referral has been started and you will be contacted to schedule an appointment."

**Get fitted for appropriate shoes that support stability and gait.** Write prescription to be processed at a medical supply company (Samaritan Medical Equipment).

**Cardiology consultation referral.** "A referral has been started and you will be contacted to schedule an appointment."

**Neurology consultation referral.** "A referral has been started and you will be contacted to schedule an appointment."

**Obtain Samaritan Lifeline or other distributor.**

**Other:**

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**Epic Documentation: .fall**

**Appendix C****Survey for Providers Implementing the *Hendrich II* and *Falls Prevention Action Guide for Providers into Practice***

1. How important is it to you to assess falls in the elderly in your clinical practice?

Not Important                      Somewhat Important                      Important                      Very Important

**Hendrich II**

2. How does the *Hendrich II* compare to other tools used in the clinic setting to assess fall risk in the elderly?

Inferior                      Similar                      Superior                      Uncertain

3. How competent do you feel using the *Hendrich II*?

Not competent                      Somewhat competent                      Competent                      Highly competent

4. Is it easy to use the *Hendrich II*?

Very difficult                      Difficult                      Easy                      Very easy

5. How much time does it take to assess your patient using the *Hendrich II*?

Less than a minute                      One – two minutes                      Three – five minutes                      More than five minutes

6. Using the *Hendrich II* takes time away from your patient visit.

Strongly disagree                      Disagree                      Agree                      Strongly agree

7. How effective do you believe the *Hendrich II* is for identifying fall risk for the elderly?

Very ineffective                      Ineffective                      Effective                      Very effective

**Falls Prevention Action Guide for Providers**

8. How does the *Falls Prevention Action Guide for Providers* compare to other tools used in the clinic setting to implement fall risk strategies for the elderly?

Inferior                      Similar                      Superior                      Uncertain

9. How competent do you feel using the *Falls Prevention Action Guide for Providers*?

Not competent                      Somewhat competent                      Competent                      Highly competent

10. Is it easy to use the *Falls Prevention Action Guide for Providers*?

Very difficult                      Difficult                      Easy                      Very easy

11. How much time does it take to determine actions and order/refer for your patient using the *Falls Prevention Action Guide for Providers*?

Less than a minute                      One – two minutes                      Three – five minutes                      More than five minutes

12. Using the *Falls Prevention Action Guide for Providers* takes time away from your patient visit.

Strongly disagree                      Disagree                      Agree                      Strongly agree

13. Is the *Falls Prevention Action Guide for Providers* effective in guiding your actions for implementations to reduce falls?

Very ineffective                      Ineffective                      Effective                      Very effective

**Both Tools**

14. Do you agree that using the *Hendrich II* and *Falls Prevention Action Guide for Providers* will help to reduce falls in the elderly?

Strongly disagree                      Disagree                      Agree                      Strongly agree

**Survey for Medical Assistants Implementing the Hendrich II into Practice**

1. Do you believe it is important to screen the elderly for risk of falling?

Not important                      Somewhat important                      Important                      Very Important

2. Do you check the patient's age to determine if a fall risk assessment is needed?

Never                      Occasionally                      Frequently                      Always

3. How competent do you feel making an assessment of the patient's gait and balance?

Not competent                      Somewhat competent                      Competent                      Highly competent

4. How competent do you feel asking questions/observing the 'Get-Up-and-Go Test: Rising from a Chair' on the *Hendrich II* risk assessment?

Not competent                      Somewhat competent                      Competent                      Highly competent

5. How easy is it to incorporate the *Hendrich II* into your work flow?

Very difficult                      Difficult                      Easy                      Very easy