DEPARTMENT: Doylestown Healthcare Partnership	
FACILITY:	
DATE OF ORIGIN: 7.14.21	**NEXT REVIEW DATE: 7.14.22**
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APPROVED BY: Network Development /DHP Managing Committee	

PURPOSE:

To assess and establish guidelines for the Fall Prevention Program, including procedure for risk assessment, preventive interventions, and post-fall management; and to outline documentation and communication procedures.

SCOPE:

This policy applies to Doylestown Healthcare Partnership Primary Care Practices.

POLICY:

It is the policy of Doylestown Healthcare Partnership to identify and be aware of patient safety issues, and to implement appropriate evidence-based and best practice safety measures to reduce the risk of falls and related injuries.

PROCEDURE:

1) Conduct a fall assessment at least annually on patients ≥ 65 years of age
   a) STEADI Assessment
   b) Timed Up & Go (TUG)

2) Implement fall prevention interventions for all at risk patients
   a) Discuss medications that may put patient at risk for serious injury related to a fall
      1. Medications
         a. Antihypertensives
         b. Diuretics
         c. Opiates
         d. Diabetic agents
         e. Anticonvulsants

f. Benzodiazepines/Anxiolytics
g. Antipsychotics/Antidepressants

3) Educate patient and/or family/caregivers changing their home environment
   a) Remove things you can trip over from stairs and places where you walk
   b) Remove small throw rugs or use double-sided tape to keep rugs from slipping
   c) Keep items you use often in cabinets you can reach easily without a step stool
   d) Have grab bars put in next to and inside the tub and next to the toilet
   e) Use non-slip mats in the bathtub and shower floors
   f) Improve lighting in your home.
   g) Have handrails and lights installed on staircases
   h) Wear well-fitting shoes with good support inside and outside the house

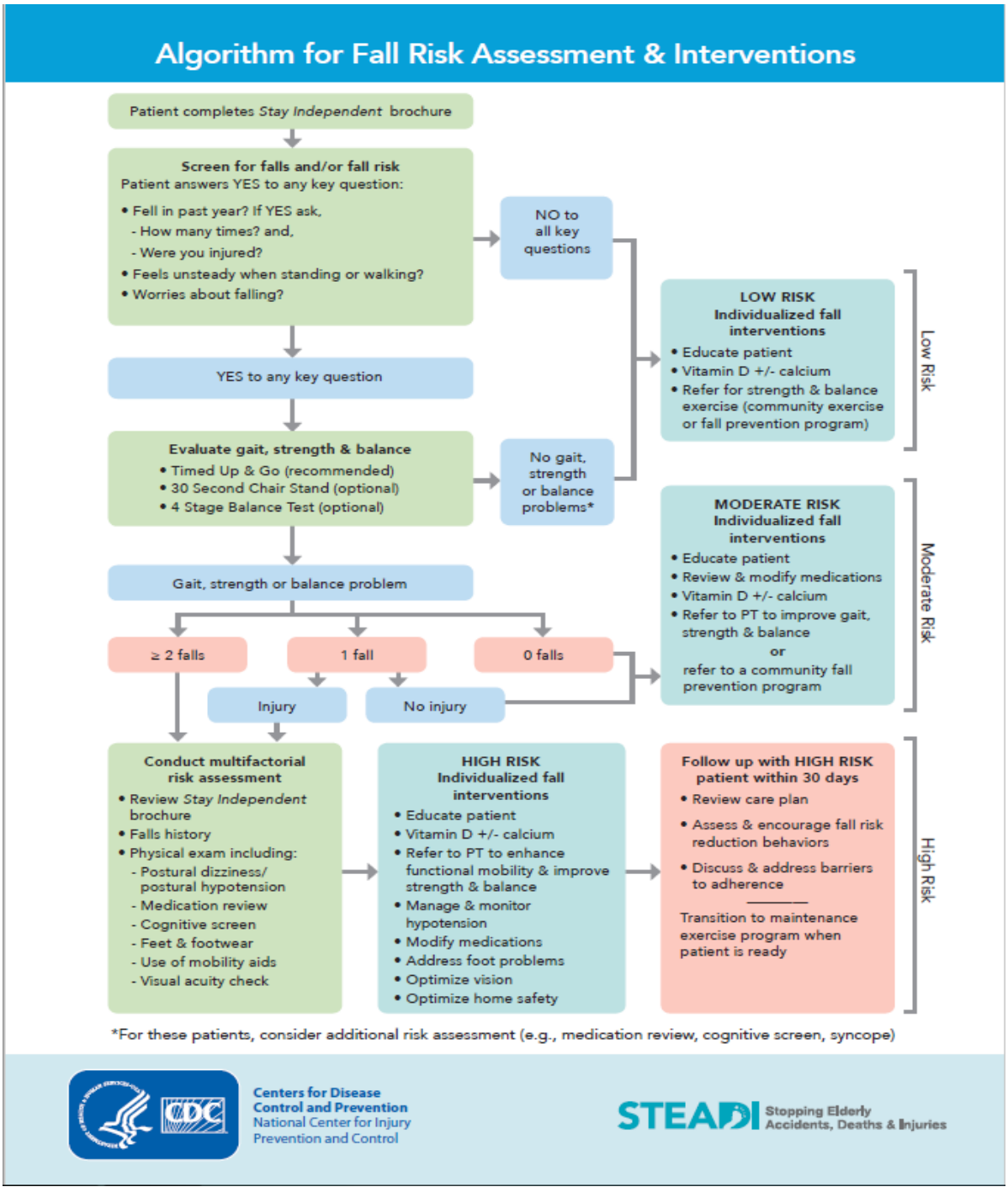
4) Instruct patient on exercise to improve balance, flexibility and strength (i.e. Tai Chi)

5) Words That Matter
   a) Falling is not part of normal aging, so we want to make sure that we reduce your risk as much as we can.
      i) Have you fallen recently?
      ii) Do you feel unsteady on your feet?
      iii) Are you afraid you may fall?

REFERENCES:

Centers for Disease Control and Prevention: Stopping Elderly Accidents, Deaths, & Injuries (STEADI) – Older Adult Fall Prevention: https://www.cdc.gov/steadi/

ADDENDUM A


Algorithm for Fall Risk Assessment & Interventions
Patient completes Stay Independent brochure
Screen for falls and/or fall risk
Patient answers YES to any key question:
• Fell in past year? If YES ask,
- How many times? and,
- Were you injured?
• Feels unsteady when standing or walking?
• Worries about falling?
NO to all key questions
YES to any key question
Evaluate gait, strength & balance
• Timed Up & Go (recommended)
• 30 Second Chair Stand (optional)
• 4 Stage Balance Test (optional)
No gait, strength or balance problems*
Gait, strength or balance problem
≥ 2 falls
1 fall
0 falls
Injury
No injury
LOW RISK
Individualized fall interventions
• Educate patient
• Vitamin D +/- calcium
• Refer for strength & balance exercise (community exercise or fall prevention program)
Low Risk
MODERATE RISK
Individualized fall interventions
• Educate patient
• Review & modify medications
• Vitamin D +/- calcium
• Refer to PT to improve gait, strength & balance
or
refer to a community fall prevention program
Moderate Risk
Conduct multifactorial risk assessment
• Review Stay Independent brochure
• Falls history
• Physical exam including:
- Postural dizziness/ postural hypotension
- Medication review
- Cognitive screen
- Feet & footwear
- Use of mobility aids
- Visual acuity check
HIGH RISK
Individualized fall interventions
• Educate patient
• Vitamin D +/- calcium
• Refer to PT to enhance functional mobility & improve strength & balance
• Manage & monitor hypotension
• Modify medications
• Address foot problems
• Optimize vision
• Optimize home safety
Follow up with HIGH RISK patient within 30 days
• Review care plan
• Assess & encourage fall risk reduction behaviors
• Discuss & address barriers to adherence
Transition to maintenance exercise program when patient is ready
High Risk
*For these patients, consider additional risk assessment (e.g., medication review, cognitive screen, syncope)
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
STEADI Stopping Elderly Accidents, Deaths & Injuries

ADDENDUM B

ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

NOTE: Always stay by the patient for safety.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steadi

Patient _____

Date _____

Time ☐ AM ☐ PM

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- ☐ Slow tentative pace
- ☐ Loss of balance
- ☐ Short strides
- ☐ Little or no arm swing
- ☐ Steadying self on walls
- ☐ Shuffling
- ☐ En bloc turning
- ☐ Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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