DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES/ ADULT SPECIAL POPULATIONS

Health Care Services Protocol # 3

Fall Management Guidelines

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I. OBJECTIVE

To effectively identify individuals who are at risk for falls and to protect them from injury and to promote their safety. (Medical University of South Carolina Medical Center Clinical Policy Manual).

II. RATIONALE

In 2003, the Ohio MR/DD system estimated that 43 percent of all injuries that are reported as MUI's (Major Unusual Incidents) are the result of a fall.

Other information about 'falls':

- Most falls occur when inidivdual are going about their usual activities of daily living.
- Individuals with a disability may not have the protective reactions to prevent serious injuries when they fall.
- Advanced age and medical conditions may increase the possibility of injury due to fall.
- The more falls an individual has, the greater the chance of injury.
- There are risk factors that increase the probability of an individual falling.

It is the goal of this protocol that risk factor assessment of individuals at increased risk for falling will result in less frequency of serious injuries related to such events. Additionally, these assessments will lead to a review of corrective actions that might prevent future falls for any one individual.

III. STANDARDS

A. A fall is defined as an event in which there is uncontrolled, downward displacement of an inidividual's body from a standing, sitting, or lying position. Individuals who are assisted to the floor by staff (and would have fallen if they hadn't had staff assistance) will also be identified as a fall. Individuals who are found on the floor and for which no

known alternate reason can be discerned will also be identified as a fall. (Adapted from the Medical University of South Carolina Medical Center Clinical Policy Manual)

B. Individuals coming into residential services will be assessed, at time of admission, for their fall risk by the assigned community nurse. *Appendix A*

C. Individuals will be re-assessed for their fall risk annually to coincide with their yearly ELP update or sooner if their health care status changes significantly. *Appendix A*

D. As indicated by the DDDS Fall Risk Assessment Tool (*Appendix A)*, any individual scoring 6 or above will have an individualized fall prevention plan as part of their nursing ELP, based on the individual's risk for falls.

E. Besides incident reporting policy requirements, the assigned nurse shall be notified when an individual on her caseload falls for falls which occur in individuals receiving service in the Shared Living Program. The following information shall, then, be forwarded to the Nursing Administrator: (1) name of person who fell, (2) age of the person who fell, (3) place and circumstances of fall, (4) body part involved or injured, and (5) health care follow-up plan.

F. Individualized fall prevention plans shall include, but need not be limited to fall prevention education and consideration of environmental, physical, medical, and other relavent factors. Some examples of teaching aides on fall prevention can be found in *Appendices B and C.*

G. Routinely, falls shall be reviewed by the assigned nurse any time there is an injury that results in the need for medical care or there are two falls that have occurred that have not required medical attention. An important step in reviewing such cases is trying to understand why the person has fallen. The review shall include consideration of the fall circumstances and internal and external risk factors (*Appendix D).* Such considerations can be reviewed during consultation, as possible, with the primary care physician. At the request of the assigned nurse, in consultation with team members as appropriate, a nurse supervisor can request an assessment by a physical/occupational therapist. She should arrange for such to occur with the assistance, as needed, of the statewide Nursing Supervisor/ Assistant Health Care Services Director. It shall be obtained in a reasonable period of time. Any undue delay shall be communicated to the Health Care Services Director.

H. The Risk Management Committee will monitor fall data on a semi-annual basis in an effort to identify significant trends and, therefore, enhance individual safety. Such monitoring results will be reviewed with the nursing staff on at least a yearly basis.

I. It shall be requested that individuals at moderate or high-risk of falling be assessed for osteoporosis by their primary care provider. The annual physical examination form (or yearly on the MAIR) shall highlight this request and reflect the content of that assessment and any prescribed treatment plan and/or follow-up.

J. The assigned nurse is responsible for the implementation of this protocol and for the communication, at team meetings, of the importance of (1) reporting falls and (2) reviewing any fall management components of an ELP to interdisciplinary team members, such as provider agency and day program managers and staff. The assigned community nurse is responsible for communicating the applicable requirements of this protocol to shared living providers who care for individuals on their caseload.

IV. REFERENCES

1. Information Notice, March 2003, Health and Safety Alerts: Falls, Ohio DMR.
2. Health Care Association of New Jersey, Best Practices Committee, Fall Management Guidelines, February 2005.
3. Medical University of South Carolina Medical Center, Clinical Policy Manual Policy – C.
4. AOTA Tips for Living, March 2003: Fall Prevention for People with Disabilities and Older Adults. Appendix B.
5. CA Department of Development Services: The Safety Net, 3rd Quarter 2003, 2 pages. Appendix C.

V. APPENDICES

A. DDDS Fall Risk Assessment. (Adapted form the Medical University of South Carolina Medical Center Clinical Policy Manual)

B. AOTA Tips for Living, March 2003: Fall Prevention for People with Disabilities and Older Adults.

C. CA Department of Development Services: The Safety Net, 3rd Quarter 2003, 2 pages.

D. Fall Risk: Internal and External Risk Factors.

Appendix A

DDDS Fall Risk Assessment Tool

Date: _____ **Region:** _____
Provider: _____ **Site/ Address:** _____

Name of Person: _____ **Date of Birth:** _____

Circle appropriate response per category, then add total points				
Points	**0**	**1**	**2**	**3**
Age	50 or below	51 to 60	61 to 69	70 or above
Mental Status	Oriented, cooperative		Oriented, uncooperative or depressed/ agitated	Confused, not oriented
Physical Status	Well	Documented orthostasis	Dizziness, vertigo, syncope	Cachexia, wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinent	Independent but incontinent; urgency/ frequency
Sensory	No vision or hearing issues	Hearing loss only	Vision loss only	Hearing and Vision Loss
Neuromotor	No paralysis or spasticity	Upper extremity only	Lower extremity only	Both upper and lower
Gait	Unable to walk/ stand (not at risk), or fully ambulated	Physically unable to walk/ stand (but may attempt to)	Walks with help (e.g. mobility aids; cane, walker, holds onto furniture, etc.)	Balance problems- walking or standing; unsteady gait
Fall History, past 6 mths.	None	Near falls or fear of falling	Has fallen one or two times	Multiple falls (more than two)
Medications	None below	1 med below	2 meds below	3 or more
Circle: alcohol, anesthetic, antihypertensive, anti-seizure, benzodiazepine, diuretics, cathartics, hypoglycemics, narcotics, psychotropics, sedative/ hypnotics.				
Subtotal Pts.				
Total Points				
0 – 5 points: Low Risk; 6-10 points: Moderate Risk; 10 or more points: High Risk * If the person scores 6 or more than implement the Safety Section of the ELP.				

Signature of Nurse: _____ **Date:** _____

(Medical University of South Carolina Clinical Policy Manual)

Fall Risk: Individual & External Factors

Individual Factors

There are particular conditions that an individual may have or exhibit which are unique to the individual. Some of these factors include, but are not limited to:

Lower extremity weakness
Balance disorders
Visual Deficits
Functional and cognitive impairment
Use of some types of medications/ poly-pharmacy
Psychotropic medications
Age
Seizure disorder
Chronic or acute pain
Cardiac medication that results in orthostasis
Chronic medical conditions
Poorly maintained assistive devices
Urinary urgency/ frequency

External Factors

These are factors related to the environment or environmental conditions. Some of these factors include, but are not limited to:

Poor lighting
Slippery floor surfaces or changes in floor surface (e.g. from carpet to tile)
Transfers/ pivots
Stairs
Lack of handrails
Wires, light cords or other objects in the environment or on the floor which an individual can trip on/over
Ill-fitting or untied shoes or ill-fitting pants
The use of adaptive devices
Uneven walking surfaces
Getting on and off of vehicles
Weather conditions such as ice and rain
Spills or clutter

(Reference 1: Information Notice, 3/2003, Health and Safety Alerts: Falls, Ohio DMR.)