Division of Developmental Disabilities Services

Community Services

Health CareServices Protocol # 3

Fall Management Guidelines

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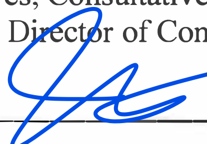
Approved by:  ______________________ **Date:** 3/8/2023

I. Objective:

A. To identify service recipients who are at risk for falls and to systematically assess fall risk factors.

B. To apply fall prevention program interventions to all service recipients to ensure a proactive, standardized approach to safety that decreases the potential for falls.

C. To assess and identify risk factors within the environment and make any necessary changes. (Exhibit C).

II. Policy:

Service recipients are assessed of their risk for falls annually and as needed due to changes in the service recipient's health or support needs status. Service providers must manage the environment to prevent falls and implement appropriate safety supports for those who are assessed as a Moderate to High Risk for falls.

III. Application:

- All service recipients receiving Residential Habilitation services from the Division of Developmental Disabilities Services (DDDS).
- All service recipients receiving Day and Employment services authorized by DDDS.
- DDDS Community Services staff and contracted Targeted Case Management staff.
- Authorized Residential Habilitation, Day Services, and Nurse Consultation Providers.

IV. Standards:

A. A fall is defined as an event in which there is uncontrolled, downward displacement of a service recipient's body from a standing, sitting, or lying position. Service recipients 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.

Service recipients who are found on the floor and for which no known alternate reason can be discerned will also be identified as a fall. Excluded are falls resulting from violent blows or other purposeful actions of another individual.

B. A Fall Risk Screening shall be completed bythe Consultative Nurse upon a service recipient's initial entry into residential habilitation services. *(Exhibit A)*. The Consultative Nurse will notify the support team members through a T-log in the electronic client data management system with the result of the screening tool.

C. Re-assessment shall be completed annually in conjunction with the service recipient's Person Centered Plan (PCP) date, whether in residential habilitation or day/employment services.

D. Re-assessment shall be completed any time there is a change in any service recipient's health, medications, or environmental status that would affect his/her risk for falls, whether in residential habilitation or day/employment services (Exhibit D.) The exhibit is intended as a list of examples/references and not as an all-inclusive list.

E. The results (score) of the Fall Risk Screening Tool shall be documented by the Consultative Nurse in the comments section under "Falls" in the Electronic Comprehensive Health Assessment Tool (ECHAT) in the electronic client data management system. If the service recipient is in the "Moderate" or "High Risk" the Fall Risk Screening Tool must be attached to the RISK section of the PCP by the Consultative Nurse. If the service recipient is in the "Low Risk" the Fall Risk Screening Tool must be attached to the bottom of the PCP as an external attachment by the Consultative Nurse.

F. Service recipients who do not have a Consultative Nurse and/or living with their natural family shall have a Fall Risk Screening Tool completed by the day service/employment provider upon admission (Exhibit A.) The provider will notify the service recipient, family/guardian, targeted case manager, and support team with the results of the screening tool. If the service recipient is in the "Moderate" or "High Risk" the Fall Risk Screening Tool must be attached to the RISK section of the PCP by the Support Coordinator/Community Navigator. If the service recipient is in the "Low Risk" the Fall Risk Screening Tool must be attached to the bottom of the PCP as an external attachment by the Support Coordinator/Community Navigator.

G. As indicated by the Fall Risk Screening Tool (Exhibit A,) any service recipient, whether in residential habilitation or day/employment services, with a score of 10 or higher or receiving anticoagulant therapy (including aspirin) will have an individualized fall prevention plan with safety supports developed within 30 days of the completed assessment to address the risk(s) and reduce the possibility of a fall. This plan shall be documented on the Significant Medical Conditions document and attached to the PCP by the Consultative Nurse or Support

Coordinator/Community Navigator if there is no Consultative Nurse assigned.

H. It shall be requested that any service recipient at "Moderate" or "High Risk" of falling be assessed for osteoporosis by their primary healthcare provider, including the need for bone density study. The Other section on page 2 of the Annual Physical Examination form (or equivalent form from the healthcare provider) shall reflect the results of that assessment and any prescribed treatment plan and/or follow-up.

I. A General Event Report (GER) will be completed in the electronic client data management system by any staff who witnesses any fall. For Shared Living Providers (SLPs) the DDDS staff who receives the report of the fall incident will generate the GER. All GERs will be reviewed by the Consultative Nurse and further interventions implemented as warranted. If the service recipient doesn't have a Consultative Nurse, the Support Coordinator/Community Navigator should initiate a review of supports conversation with the support team and make any recommended changes.

J. Individualized fall prevention plans shall include, but need not be limited to, fall prevention education and consideration of environment, physical, medical, and other relevant factors.

K. Falls shall be reviewed by the Consultative Nurse (or Support Coordinator/Community Navigator if no Consultative Nurse) any time there is an injury that results in the need for medical care. An important step in reviewing such cases is trying to understand why the service recipient fell. The review shall include consideration of the fall circumstances and intrinsic and extrinsic risk factors (Exhibit D.) Such considerations can be reviewed during consultation with the healthcare provider, if possible. In consultation with support team members, as appropriate, the Consultative Nurse/Support Coordinator/Community Navigator can request an assessment by a physical/occupational therapist. This may include an environmental assessment to identify fall risks that may be present in the service recipient's environment.

L. The Consultative Nurse (or Support Coordinator/Community Navigator if no Consultative Nurse) is responsible for reporting the results of the Fall Risk Screening tool to the support team members through a T-log in the electronic client data management system. A fall prevention plan with safety supports will be developed with the support team (when warranted, as described in G. above) and included in the Significant Medical Conditions document attached to service recipient's PCP.

V. References:

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2015). *A fall prevention checklist for older adults.* Retrieved from Check for Safety: A Home Fall Prevention Checklist for Older Adults (cdc.gov)

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, STEADI. (2017). *Fact sheet risk factors for falls.* Retrieved from Fact Sheet Risk Factors for Falls (cdc.gov)

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2017). *Fact sheet medications linked to falls.* Retrieved from Fact Sheet Medications Linked To Falls (cdc.gov)

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, STEADI. (2021). *Coordinated care plan to prevent older adult falls*. Retrieved from Steadi-Coordinated-Care-Plan.pdf (cdc.gov)

Minnesota Hospital Association. (2022). *Falls road map.* Retrieved from Falls Road Map.pdf (mnhospitals.org)

Virginia Department of Behavioral Health and Developmental Services, Office of Integrated Health &Safety Information. (2019). *Fall prevention health & safety alert.* Retrieved from heatlh-safety-alert-falls-prevention-092019.pdf (virginia.gov)

VI. Exhibits:

A. DDDS Fall Risk Screen Tool
B. Fall Risk Screening Tool Guidelines
C. CDC: A Fall Prevention Checklist for Older Adults
D. CDC: Fact Sheet; Risk Factors for Falls

Exhibit A

Division of Developmental Disabilities Services
Community Services
Fall Risk Screening Tool

Name: ______________________________ **Site:** ________________________________
Date of Birth: _______________________ **MCI:** ________________________________
Prepared by: _________________________ **Date of Screening:** ____________________

Directions: This assessment is to be completed on all service recipients upon admission and annually in conjunction with the PCP and any significant changes in health status. Check applicable items that best apply and indicate points to the right. Add points and note total score below.	**Points**
Mental Status: □ **(0 pt)** Oriented/alert at all times/ or comatose □ **(1 pt)** Lethargic/forgetful/inconsistent orientation or response to stimuli □ **(2 pts)** Confused-non-agitated/ highly distractible/ depressed/ uncooperative/ impaired judgment □ **(3 pts)** Confused/agitated/aggressive/non-purposeful behavior/impulsive	
Physical Status: □ **(0 pt)** Normal/well/healthy/no remarkable medical and physical problems □ **(1 pt)** Dyspnea/respiratory conditions □ **(2 pts)** Dyncope/orthostatic hypotension/joint difficulties (arthritis, contractures) □ **(3 pts)** Seizure disorder/ cachexia/wasting/LE amputation/vestibular imbalance	
Elimination: □ **(0 pts)** Independent and continent □ **(1 pt)** Catheter and/or ostomy/ dependent (uses protective undergarments) □ **(2 pts)** Elimination with assistance/occasional incontinence □ **(3 pts)** Independent and incontinent (urgency/frequency)	
Sensory: □ **(0 pt)** No hearing or vision problems □ **(1 pt)** Hearing loss/impairment only □ **(2 pts)** Vision loss/impairment only □ **(3 pts)** Has both hearing and vision loss/impairments	
Neuromotor: □ **(0 pt)** Normal muscle tone/ no weakness/ no paralysis/ no spasticity □ **(1 pt)** Upper extremities only (weakness/paralysis/spasticity/athetosis) □ **(2 pts)** Lower extremities only (weakness/paralysis/spasticity/athetosis) □ **(3 pts)** Both upper and lower extremities (weakness/paralysis/spasticity/athetosis)	
Gait: □ **(0 pt)** Independent ambulator/ non-ambulatory/ immobile □ **(1 pt)** Non-ambulatory/has bed mobility/has wheelchair mobility □ **(2 pts)** Independent ambulator with assistive device (i.e. walker/cane) □ **(3 pts)** Ambulatory with physical assistance and assistive device/unsteady gait	
History of Falling Within Past 3 Months: □ **(0 pt)** None □ **(1 pt)** Near falls or fear of falling □ **(2 pts)** 1-2 falls □ **(3 pts)** Multiple falls (more than 2)	
Medication Classifications: __ Antihistamine __Antihypertensives __Antiseizure/Antiepileptic __ Benzodiazepines __Cathartics __Diuretics __Hypoglycemic agents __Psychotropics __Sedatives/Hypnotics __Narcotics __Other **On the above medication classifications, indicate how many medications in each group the service recipient is currently taking, or took prior to admission. Add each medication in each classification to get the total points:** □ **(0 pts)** No medications □ **(1 pt)** 1 medication □ **(2 pts)** 2 medications □ **(3 pts)** 3 or more	
0- 9 points: Low risk 10- 17 Moderate risk 18 or more: High risk	**Total Score:**
Persons scoring 10 or more or are receiving anticoagulant therapy (including Aspirin) will have an individualized fall prevention plan with safety supports developed to address the risk(s) and reduce the possibility of a fall. The plan will be reflected in the PCP and on the Significant Medical Conditions document.	

Exhibit B

Division of Developmental Disabilities Services
Community Services
Fall Risk Screening Tool Guidelines

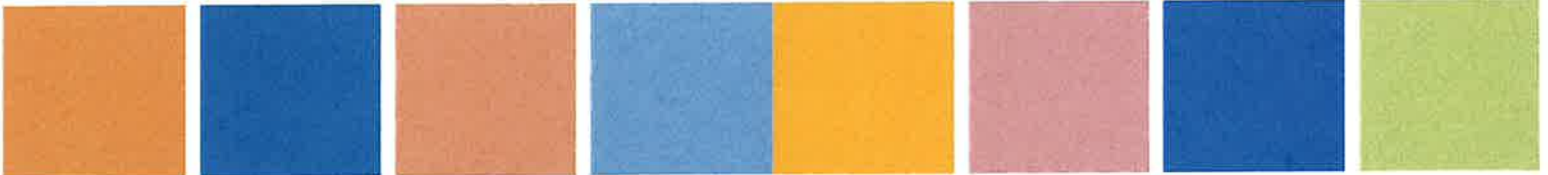
FALL RISK SCREENING FORM	KEY POINTS
1. Note the service recipient's general information.	1. Service recipient's name, date of birth, MCI number, and site.
2. Person completing the form should sign it and noting the date of completion.	2. Sign under the section of "prepared by" and "date of screening" for completion date
3. Score the service recipient's mental status or level of cognition (using 0-3 points).	3. Observed if service recipient is confused (unable to make purposeful decision, has disorganized thinking and memory impairment); disoriented (lack of awareness of or is mistaken about time, place or person); agitated (shows fearful affect, makes frequent movements, is anxious).
4. Score the service recipient's physical status using 0-3 points.	4. Note for service recipient's respiratory status (such as dyspnea), musculoskeletal status (such as lower extremity amputation) and neurologic status (such as seizure disorder).
5. Score the service recipient's elimination status using 0-3 points.	5. Note for alternation in urination (such as frequency, urgency, incontinence).
6. Score the service recipient's sensory status using 0-3 points.	6. Note for service recipient's vision and hearing impairments (considering utilization of eye glasses and hearing aides).
7. Score the service recipient's neuromotor status using 0-3 points	7. Note for service recipient's muscle tone. Identifying if the individual has weakness, paralysis or even has movement disorders.
8. Score the service recipient's ambulation and functional mobility status using 0-3 points.	8. Note if service recipient is bed bound, wheelchair bound, or can walk functionally with or without assistive device or physical assistance.
9. Score the service recipient's history of falling within the last 3 months using 0-3 points depending on fall frequency.	9. Refer to Fall Management Guidelines for the definition of a fall. Refer to service recipient's electronic record for the number of falls for the past 3 months.
10. Score the service recipient's total number of prescribed medications.	10. Note for different types/categories of prescribed medications, with particular attention to medications that affect blood pressure, cardiac function, and cognition, or that cause dizziness or lightheadedness. Also, note if there are changes in medication and/or dosage in the past 5 days.
11. Total the score from each category and identify the fall risk status of the service recipient.	11. Use the fall risk categories: Low risk; Moderate risk or High risk. If the service recipient has a score of 10 or more or is receiving anticoagulant therapy, an individualized fall prevention plan with safety supports shall be developed and be a part of the PCP and Significant Medical Conditions document.

Check for Safety

A Home Fall Prevention Checklist for Older Adults

This checklist was produced with support from the MetLife Foundation.

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



For more information, contact:
Centers for Disease Control and Prevention
1(800) CDC-INFO (232-4636)
www.cdc.gov/steadi

CS259944B

2015

"Making changes in our home to prevent falls is good for us and for our granddaughter when she comes to visit."

FALLS AT HOME

Each year, thousands of older Americans fall at home. Many of them are seriously injured, and some are disabled. In 2011, nearly 23,000 people over age 65 died and 2.4 million were treated in emergency departments because of falls.

Falls are often due to hazards that are easy to overlook but easy to fix. This checklist will help you find and fix those hazards in your home.

The checklist asks about hazards found in each room of your home. For each hazard, the checklist tells you how to fix the problem. At the end of the checklist, you'll find other tips for preventing falls.

"Last Saturday our son helped us move our furniture. Now all the rooms have clear paths."

FLOORS: Look at the floor in each room.

Q: When you walk through a room, do you have to walk around furniture?

☐ Ask someone to move the furniture so your path is clear.

Q: Do you have throw rugs on the floor?

☐ Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.

Q: Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?

☐ Pick up things that are on the floor. Always keep objects off the floor.

Q: Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

☐ Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

STAIRS AND STEPS: Look at the stairs you use both inside and outside your home.

Q: Are there papers, shoes, books, or other objects on the stairs?

- [ ] Pick up things on the stairs. Always keep objects off stairs.

Q: Are some steps broken or uneven?

- [ ] Fix loose or uneven steps.

Q: Are you missing a light over the stairway?

- [ ] Have an electrician put in an overhead light at the top and bottom of the stairs.

Q: Do you have only one light switch for your stairs (only at the top or at the bottom of the stairs)?

- [ ] Have an electrician put in a light switch at the top and bottom of the stairs. You can get light switches that glow.

Q: Has the stairway light bulb burned out?

- [ ] Have a friend or family member change the light bulb.

Q: Is the carpet on the steps loose or torn?

- [ ] Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.

Q: Are the handrails loose or broken? Is there a handrail on only one side of the stairs?

- [ ] Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.

Photo courtesy of Jake Pauls

KITCHEN: Look at your kitchen and eating area.

Q: Are the things you use often on high shelves?

- [ ] Move items in your cabinets. Keep things you use often on the lower shelves (about waist level).

Q: Is your step stool unsteady?

- [ ] If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BATHROOMS: Look at all your bathrooms.

Q: Is the tub or shower floor slippery?

- [ ] Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Q: Do you need some support when you get in and out of the tub or up from the toilet?

- [ ] Have grab bars put in next to and inside the tub and next to the toilet.

Check for Safety

Check for Safety

BEDROOMS: Look at all your bedrooms.

Q: Is the light near the bed hard to reach?

☐ Place a lamp close to the bed where it's easy to reach.

"I put a lamp on each side of my bed. Now it's easy to find the light if I wake up at night."

Q: Is the path from your bed to the bathroom dark?

☐ Put in a night-light so you can see where you're walking. Some night-lights go on by themselves after dark.

Other Things You Can Do to Prevent Falls

- ☐ Do exercises that improve your balance and make your legs stronger. Exercise also helps you feel better and more confident.

- ☐ Have your doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- ☐ Have your eyes checked by an eye doctor at least once a year and update your glasses.
- ☐ Get up slowly after you sit or lie down.
- ☐ Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.
- ☐ Improve the lighting in your home. Put in brighter light bulbs. Florescent bulbs are bright and cost less to use.
- ☐ It's safest to have uniform lighting in a room. Add lighting to dark areas. Hang lightweight curtains or shades to reduce glare.
- ☐ Paint a contrasting color on the top edge of all steps so you can see the stairs better. For example, use a light color paint on dark wood.

"I feel stronger and better about myself since I started taking Tai Chi."

Other Safety Tips

- ☐ Keep emergency numbers in large print near each phone.
- ☐ Put a phone near the floor in case you fall and can't get up.
- ☐ Think about wearing an alarm device that will bring help in case you fall and can't get up.

FACT SHEET

Risk Factors for Falls

Research has identified many risk factors that contribute to falling—some of these are modifiable.

Most falls are caused by the interaction of multiple risk factors. The more risk factors a person has, the greater his/her chances of falling. Healthcare providers can lower a person's risk by reducing or minimizing that individual's risk factors.

What healthcare providers can do

To prevent falls, providers should talk to their patients about their health goals. Then, determine which modifiable fall risk factors can be addressed to help them meet their goals.

Effective clinical and community interventions exist for the following fall risk factors:

- Vestibular disorder/poor balance
- Vitamin D insufficiency
- Medications linked to falls
- Postural hypotension
- Vision impairment
- Foot or ankle disorder
- Home hazards

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.

Risks factors are categorized as intrinsic or extrinsic:

INTRINSIC | Factors

- Advanced age
- Previous falls
- Muscle weakness
- Gait & balance problems
- Poor vision
- Postural hypotension
- Chronic conditions including arthritis, stroke, incontinence, diabetes, Parkinson's, dementia
- Fear of falling

EXTRINSIC | Factors

- Lack of stair handrails
- Poor stair design
- Lack of bathroom grab bars
- Dim lighting or glare
- Obstacles & tripping hazards
- Slippery or uneven surfaces
- Psychoactive medications
- Improper use of assistive device

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2017

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