



**Linkages with Primary Care
Providers**
&
**Changes Within the HealthCare
System**

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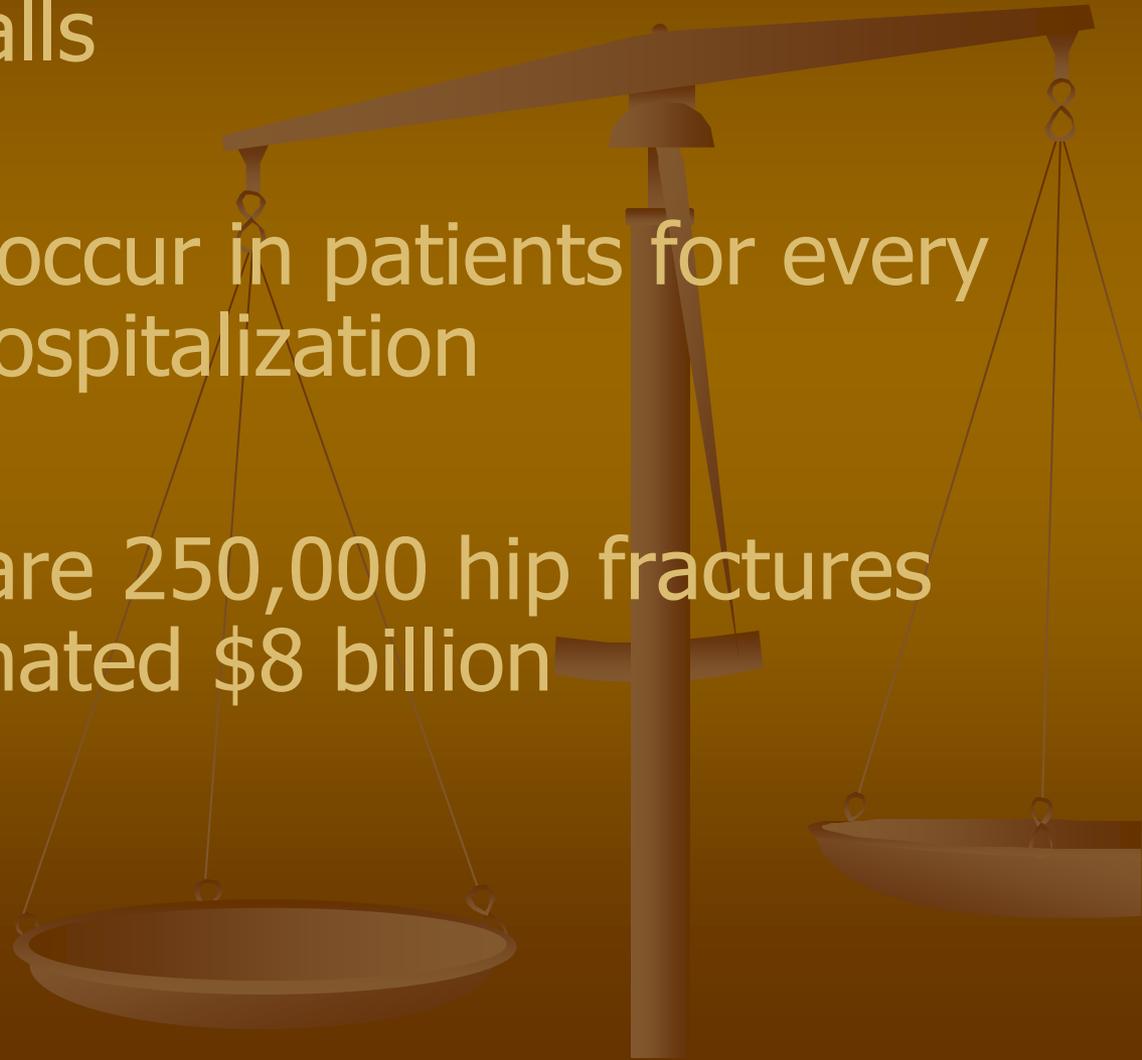
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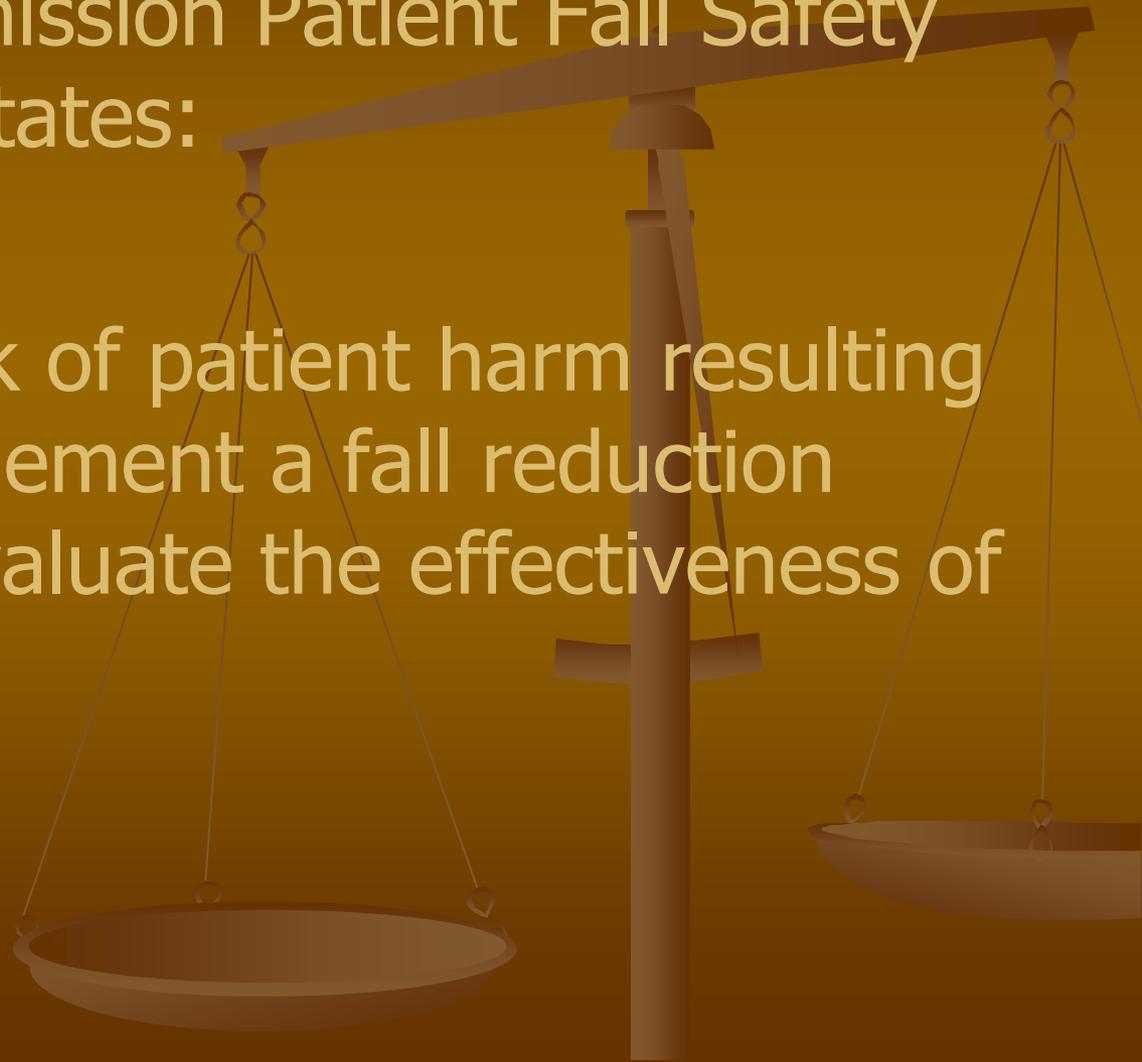
Why Prevent Falls?

- Nearly 10,000 elder Americans die annually from falls
(CDC, 2009)
- Four to 12 falls occur in patients for every 1,000 days of hospitalization
(Kimbell, 2002)
- Annually there are 250,000 hip fractures costing an estimated \$8 billion
(CDC, 2009)



FALL RISK ASSESSMENTS IN THE HOSPITAL

- The Joint Commission Patient Fall Safety goal/standard states:
- “Reduce the risk of patient harm resulting from falls. Implement a fall reduction program and evaluate the effectiveness of the program.”



FALL RISK ASSESMENTS IN THE HOSPITAL

UTMC Fall Standard of Care

According to our Nursing Service Standard of Care D21, Fall prevention, we assess every patient for falls:

On admission.

Daily

Post-fall

After a significant change in patient condition

After any pertinent medication changes

UTMC now uses the Morse fall scale for patient fall assessment.

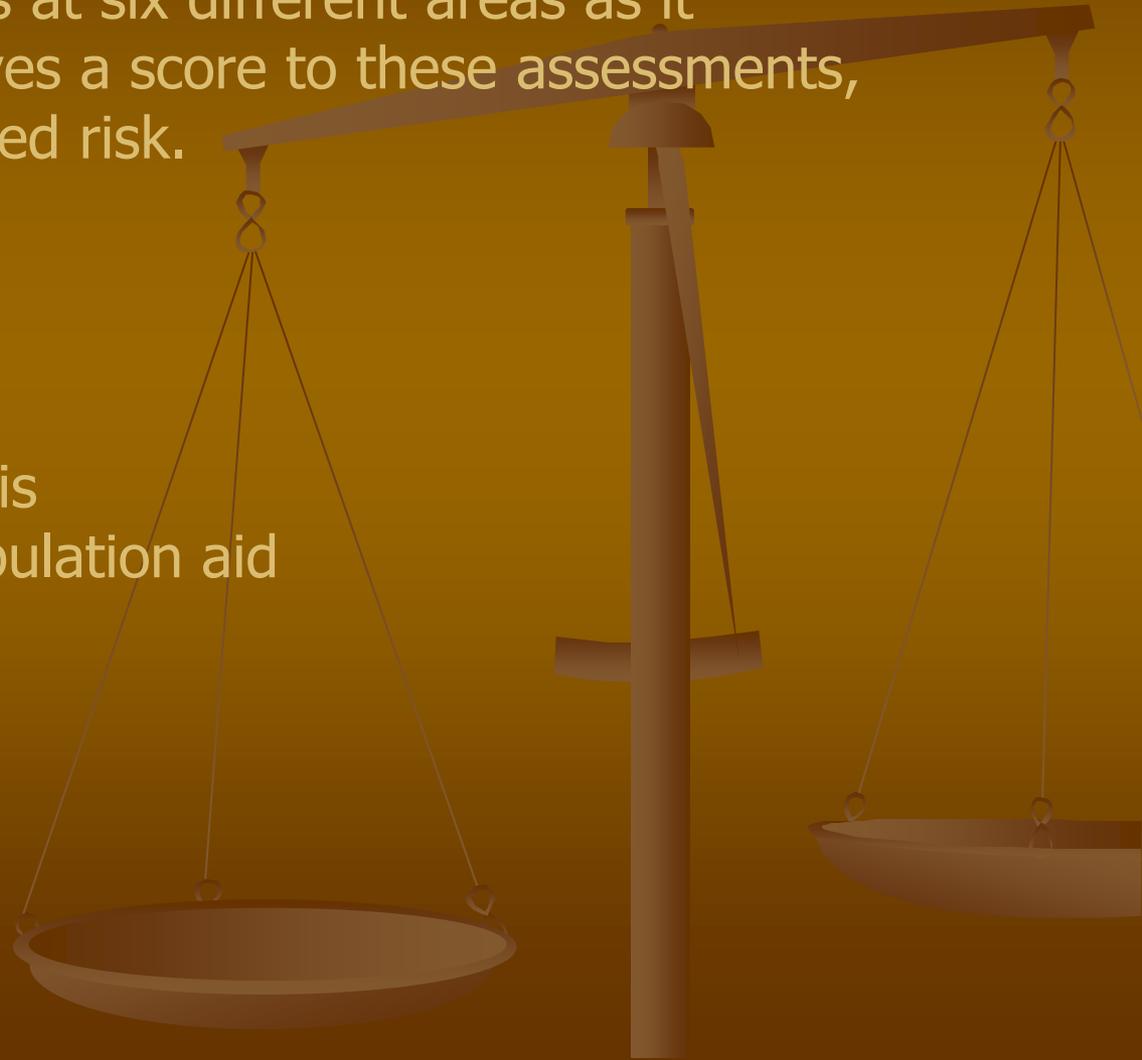
FALL RISK ASSESMENTS IN THE HOSPITAL

The Morse Fall Scale looks at six different areas as it relates to patients and gives a score to these assessments, depending on the calculated risk.

These areas include:

- History of falling
- Any secondary diagnosis
- Use of any type of ambulation aid
- IV therapy
- Type of gait
- Mental status

(Morse, 1997)



FALL RISK ASSESMENTS IN THE HOSPITAL

Morse Fall Scale

Variables	Numeric Values	Score
1. History of falling	No	0
	Yes	25
2. Secondary diagnosis	No	0
	Yes	15
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture		0
		15
		30
4. IV or IV Access	No	0
	Yes	20
5. Gait Normal/bed rest/wheelchair Weak Impaired		0
		10
		20
6. Mental status Oriented to own ability Overestimates or forgets limitations		0
		15

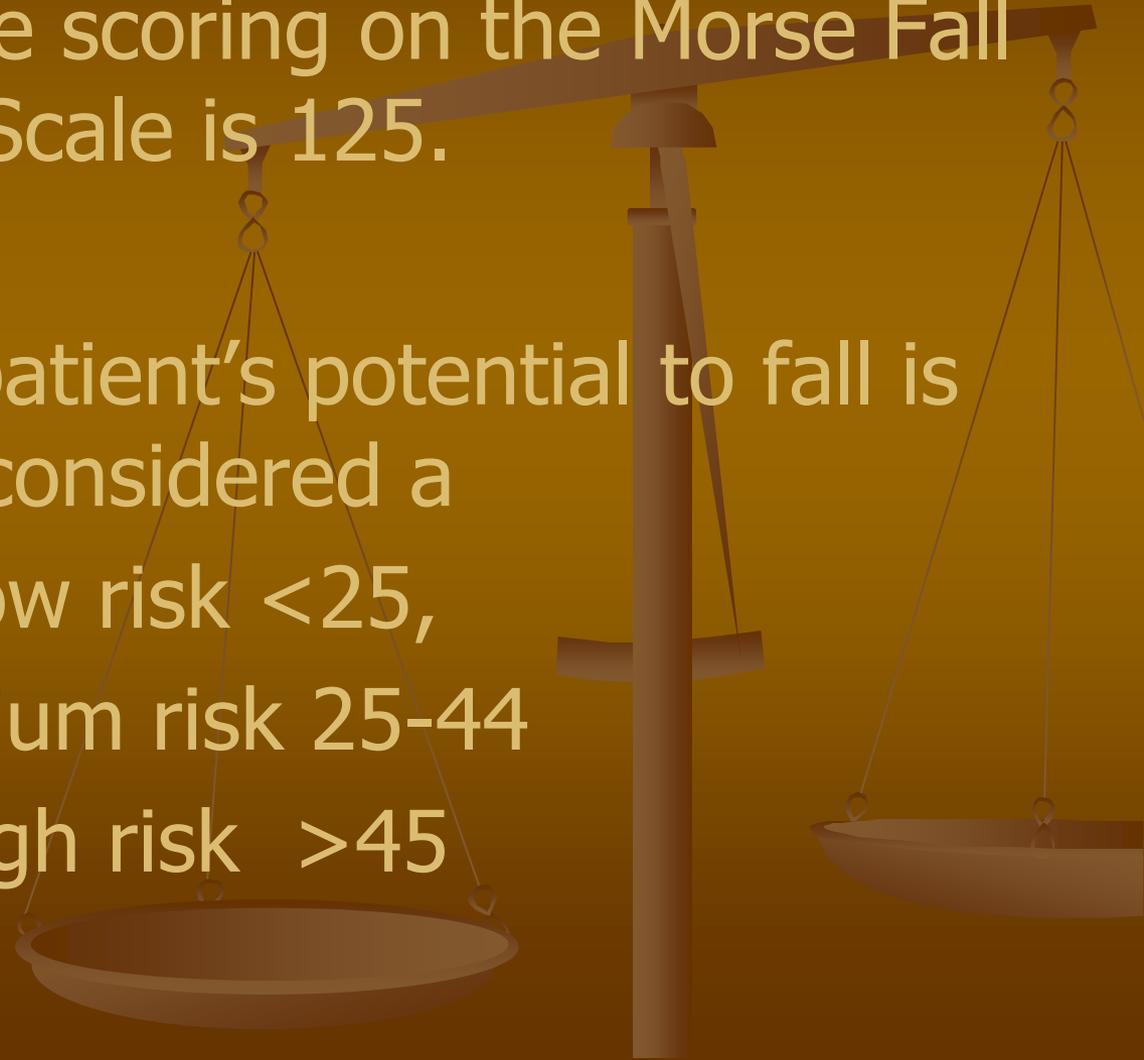
Morse Fall Scale Score = Total

FALL RISK ASSESSMENTS IN THE HOSPITAL

The Total possible scoring on the Morse Fall Scale is 125.

At UTMC, the patient's potential to fall is considered a

- Low risk <25,
- Medium risk 25-44
- High risk >45



TINETTI BALANCE ASSESSMENT TOOL

TINETTI BALANCE ASSESSMENT TOOL

Tinetti ME, Williams TF, Mayewski R, Fall Risk Index for elderly patients based on number of chronic disabilities. Am J Med 1986;80:429-434

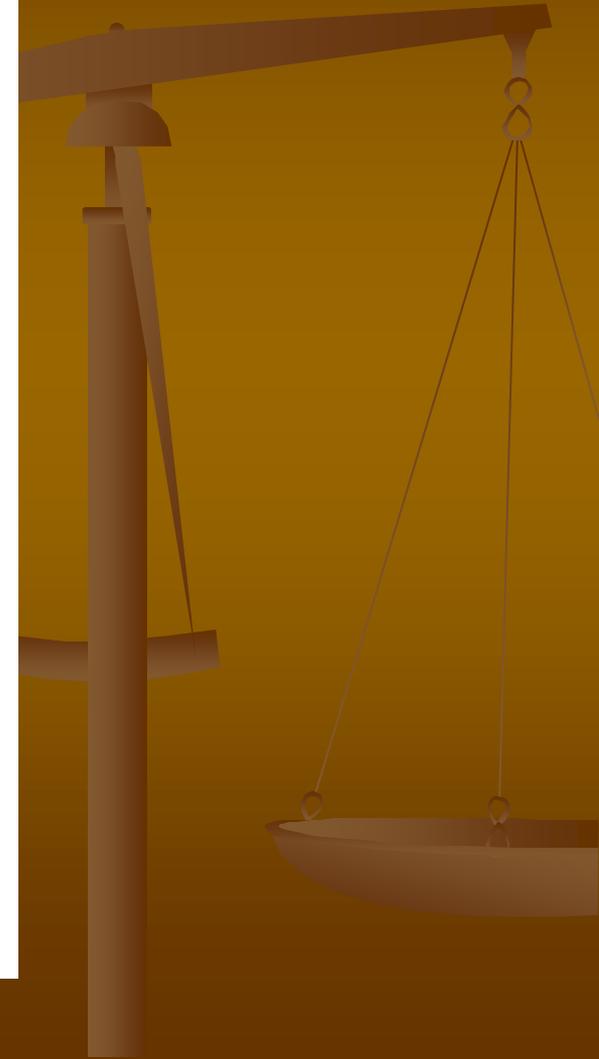
PATIENTS NAME _____ D.o.b. _____ Ward _____

BALANCE SECTION

Patient is seated in hard, armless chair;

		Date	
Sitting Balance	Leans or slides in chair	= 0	
	Steady, safe	= 1	
Rises from chair	Unable to without help	= 0	
	Able, uses arms to help	= 1	
	Able without use of arms	= 2	
Attempts to rise	Unable to without help	= 0	
	Able, requires > 1 attempt	= 1	
	Able to rise, 1 attempt	= 2	
Immediate standing Balance (first 5 seconds)	Unsteady (stagers, moves feet, trunk sway)	= 0	
	Steady but uses walker or other support	= 1	
	Steady without walker or other support	= 2	
Standing balance	Unsteady	= 0	
	Steady but wide stance and uses support	= 1	
	Narrow stance without support	= 2	
Nudged	Begins to fall	= 0	
	Stagers, grabs, catches self	= 1	
	Steady	= 2	
Eyes closed	Unsteady	= 0	
	Steady	= 1	
Turning 360 degrees	Discontinuous steps	= 0	
	Continuous	= 1	
	Unsteady (grabs, staggers)	= 0	
	Steady	= 1	
Sitting down	Unsafe (misjudged distance, falls into chair)	= 0	
	Uses arms or not a smooth motion	= 1	
	Safe, smooth motion	= 2	
	Balance score		/16
			/16

P.T.O.



BERG BALANCE TEST

Berg Balance Test

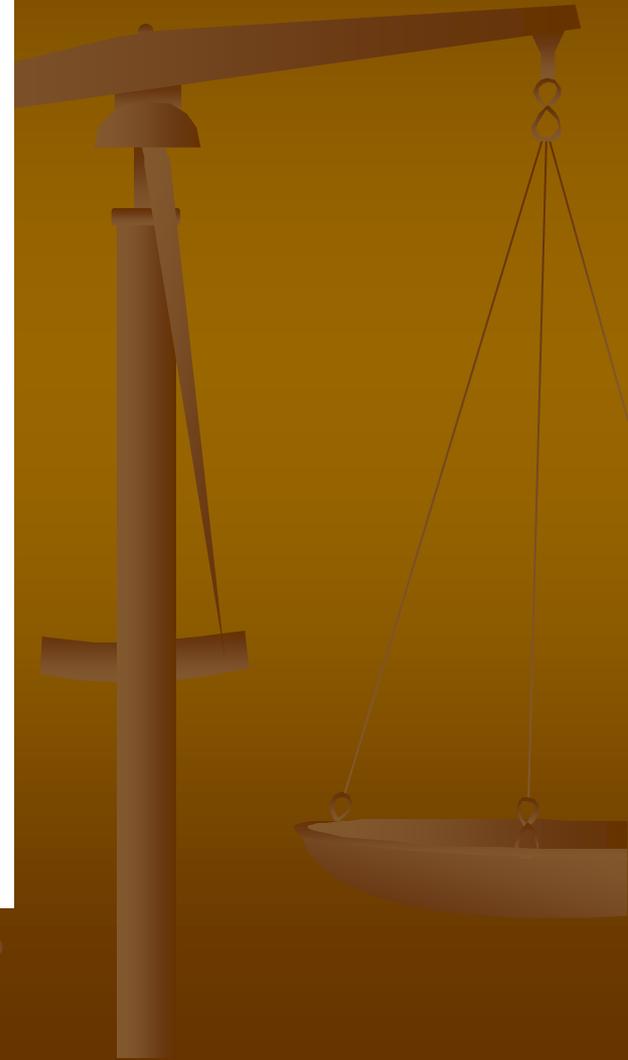
Name _____ Date _____
Location _____ Rater _____

GENERAL INSTRUCTIONS

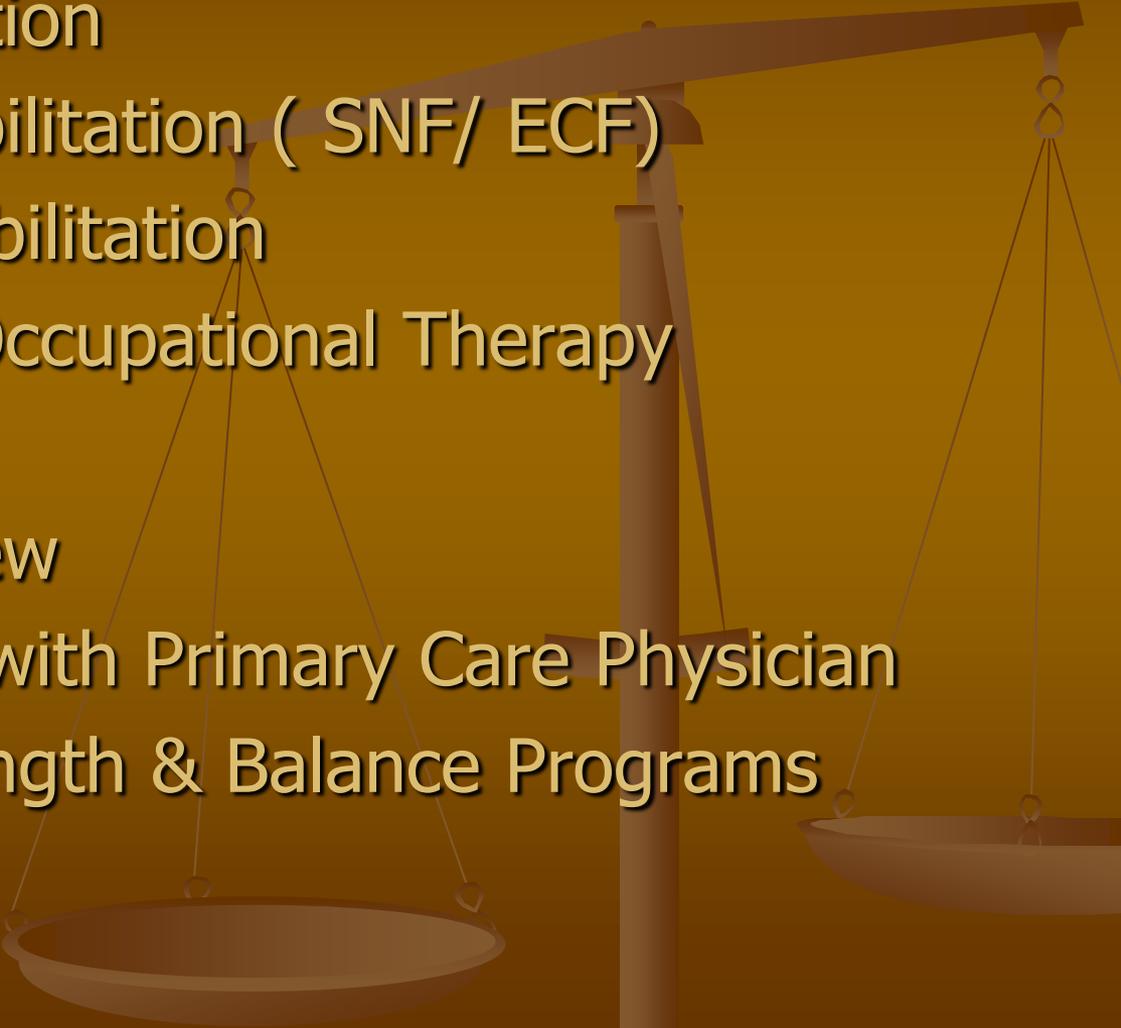
Please demonstrate each task and/or give instructions as written. When scoring, please record the lowest response category that applies for each item.

In most items, the subject is asked to maintain a given position for specific time. Progressively more points are deducted if the time or distance requirements are not met, if the subject's performance warrants supervision, or if the subject touches an external support or receives assistance from the examiner. Subjects should understand that they must maintain their balance while attempting the tasks. The choices of which leg to stand on or how far to reach are left to the subject. Poor judgment will adversely influence the performance and the scoring.

Equipment required for testing are a stopwatch or watch with a second hand, and a ruler or other indicator of 2, 5 and 10 inches (5, 12.5 and 25 cm). Chairs used during testing should be of reasonable height. Either a step or a stool (of average step height) may be used for item #12.



AT OF DISCHARGE...



1. Acute Rehabilitation
2. Sub acute Rehabilitation (SNF/ ECF)
3. Outpatient Rehabilitation
4. Home Physical/Occupational Therapy
5. Vision Screening
6. Medication Review
7. Communication with Primary Care Physician
8. Community Strength & Balance Programs

FALL PREVENTION ROOMS

- Bed controls at fingertips
- Bed alarm
- Bedside commode placed along-side bed (replaces urinal)
- Non-skid floor
- Room illuminated at all times



- Bed trapeze
- Falls prevention poster
- Non-exit side rails up for support
- Exit side head rail up for support and foot rail down at all times.
- Movable hand rail (Hemi-walker) within reach

Non-slip floor mat absorbs fluids, food, & stool, and prevents slips

WHAT CAN WE DO TO HELP?

- Encourage older adults to get evaluated
 - Better reporting of ER visits for falls
 - Know your community resources
 - Make appropriate referrals
 - Network with other Injury Prevention personnel
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