DBHDS

Fall Risk Assessments—Guidance Document
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Historically, individuals who are at significant risk of falls were served in institutional settings. Increasingly those individuals are being served in the community at various levels of care. Many clients already being served are aging, have, or are now developing medical problems, which increase the risk for falls. The intent of this regulation is for providers at every level of care to review the populations they serve and develop a risk assessment for the health and safety of the individuals who are most likely to be at risk to experience falls.

This Guidance Document is merely one suggested format for developing such a risk assessment policy and procedure. Providers may feel free to develop other policies, or use other instruments, that effectively address the regulation. These are *suggested* guidelines.

Individuals who may be at higher risks for falls include (but are not limited to) those who:

1. Have a history of falls;
2. Are experiencing delirium;
3. Are on medications, which may cause drowsiness, or have recently experienced a change in medications which may cause drowsiness;
4. Have a history of Hypotension *(low blood pressure) or Postural Hypotension (changes in blood pressure when changing positions, sitting to standing may complain of being dizzy, lightheaded)*
5. Have impaired mobility, *include use of cane, walker and wheelchair. Is the individual able to transfer from wheelchair to toilet, car or van with or without assistance?*
6. Impaired vision,
7. History of low or unstable blood sugar,
8. Are currently intoxicated, or withdrawing from alcohol or other drugs, and

Screening for such fall risks can be as simple as the provider including likely high-risk indicators on the form they use to assess the health history of the individuals they serve. (*Example: Use Yes or No screening questions to the indicators you determine may be present in your population, if yes to a determined number, implement the formal assessment.)*

Individuals who have high-risk indicators should be more formally assessed.
There are many fall risk assessment tools available. ***One*** of the most common is the Morse Fall Scale. It's simple, brief, easy to understand and use, and available free on the Internet. *Other excellent sources include Department of Veteran's Administration for Fall Risk Assessments as well as searching the web under fall risk assessment for resources to customize the assessment tool.*
Providers are also free to develop their own assessment tool.

Some *suggested* Prevention/Management plans could address such things as:

- Staff, client, and/or family education about fall risks, medication side effects & food/drug interactions, adequate and balanced nutrition.
- What kind of assistance is to be provided to an individual who is a fall risk; i.e., since 'assisting' an individual may increase fall risk. Before assisting, assess coordination & balance.
- Use, when appropriate, of assistive devices.

Some *suggested* ways of reducing fall risks in the environment:

- In residential & acute care settings, clients should be placed in beds that allow exiting from their strongest side, *also evaluate environment for placement of furniture, access to the bathroom, avoid slippery rugs and have night lights,*
- Placing personal items within easy reach.
- Ensuring a safe environment—clean up spills, clutter, electrical cords, *also evaluate environment for placement of furniture, access to the bathroom, slippery rugs.*

While there are a number of resources available, this website link may be helpful & you can find the Morse Assessment Scale there:
http://www.patientsafety.gov/FallPrev/Howto.html
If you do an Internet search for "fall risks", you'll find a significant amount of information, some of which may be particularly tailored to the services you are providing.