CONSIDERATIONS:

1. The likelihood of falling and of being seriously injured increases with age.
   a. Falls are the leading cause of accidental death in people 65 years of age and older
   b. Advancing age, physical changes and poly-pharmacy contribute to fall risk
2. High risk populations for falls include:
   a. Adults age 65 and older
   b. Patients with history of falls
   c. Patients with balance and/or gait difficulties
   d. Patients with visual, cognitive or functional deficits
3. Guidance for OASIS question M1910 specifically states: "*The multi-factor falls risk assessment must include at least one standardized tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered as indicated in the instructions."* It further goes on to say: *"An agency may use a single comprehensive multi-factor fall risk assessment tool that meets the criteria as described in the item intent."*

   The validity of the multi-factorial fall risk assessment tool (MAHC-10) developed by the Missouri Alliance for Home Care (MAHC) Fall Prevention Benchmarking Initiative has been tested and determined to be valid for initial screen for fall risk, including bed-bound patients and those with severe mobility limitations. Home Health VNA uses this single tool to determine fall risk for all patients,
4. HHQI indicates:
   a. Falls risk screening using multi-factorial risk factors is strengthened when a valid standardized mobility test is administered
   b. "A multifactorial fall risk assessment plus TUG plus hospitalization risk assessment plus clinical decision-making will identify patients at risk for falling"

EQUIPMENT:

Multi-factor fall risk assessment tool (MAHC-10 attached)

Standardized valid fall risk assessment tool (Instructions for TUG included in procecedure)

TUG test requirements

Watch with second hand (or other timing device)

10-foot measure or tape measure

POLICY:

1. HHVNA Policy is to conduct the MAHC-10 assessment with every SOC, ROC and Recert. The clinician responsible for completing the OASIS assessment is responsible for the MAHC-10. The MAHC-10 is found in the forms tab in Mobilewyse and should be added to the appropriate time points for administration.
2. When physical therapists are responsible for the OASIS, they will conduct the MAHC-10 and will also conduct other validated assessments, such as the TUG, Tinetti, or others in addition to the MAHC-10, based on individual patient characteristics. When PT is a secondary discipline in the case, the PT is not required to repeat the MAHC-10 but should conduct a standardized mobility test based on patient limitations.
3. For patients who experience a fall during the episode of care, the MAHC-10 will be reassessed by the primary clinician/case manager in order to determine whether additional interventions or referrals must be made.

PROCEDURE:

1. As part of SOC and ROC, ask the patient about:
   a. History of falls, frequency, symptoms at time of fall
   b. Fear of falling, and if patient is curtailing activities
2. Perform a medication review, including all prescribed and over-the-counter medications
3. Perform physical assessment including:
   a. neurologic status, including cognition, visual acuity, and lower extremity sensation/ proprioception
   b. cardiovascular status, including heart rate/rhythm and postural pulse/blood pressure
   c. musculo-skeletal status of lower extremities
   d. evaluation of ambulation, including gait and balance
   e. evaluation of feet and footwear
4. Perform functional assessment, asking patient to demonstrate
   a. ADL/IADL performance
   b. Use of assistive devices
5. Perform the MAHC-10.
6. If PT is conducting the OASIS assessment, also perform a standardized/validated test such as TUG. TUG instructions:
   a. Prepare for test.
      i. Measure a 10 foot distance from a standard chair
      ii. Patient should sit comfortably in chair
      iii. Explain or demonstrate the test before proceeding.
      iv. Patient should wear eyeglasses, if normally used
      v. Patient should use assistive devices (cane, walker, etc.) as usual

Adopted VNAA; Approved Policy Committee 09/24/13

   b. Ask patient to perform the following activity:
      i. Raise to standing on hearing: "Ready, set, GO." (Begin timing on "Go")
      ii. Walk to destination point (10 foot walk), turn around and return to sit in chair
   c. When patient sits down, stop timing. Patient is scored according to the time in seconds required to complete the entire task.
   d. Scoring: 14 or more seconds = Fall Risk
6. Review number and severity of multi-factor risk factors and TUG score.
7. If either assessment indicates fall risk, provide interventions appropriate to risk factors. See procedure: *Safety - Fall Precautions*,

AFTER CARE:

1. Document in patient's record:
   a. Results of multi-factor test, including areas indicating risk
   b. Results of standardized test (TUG = number of seconds
   c. Instructions given to patient/caregiver
   d. Patient's ability to understand the mobility tool utilized
   e. Patient's response to fall risk assessment.
   f. Any communication with physician or team members
2. Coordinate care with physician, communicating severity of risk and recommendations. See procedure *Safety - Fall Precautions*.
3. Communicate with patient/caregiver/family about concerns and recommendations, including need for supervision an assistance if needed.
4. Instruct the patient/caregiver in safety measures that should be implemented, including short term measures, to keep patient safe until next visit.

REFERENCE:

American Geriatric Society/British Geriatric Society. (2010). Clinical Practice Guideline: Prevention of Falls in Older Persons. Accessed on September 2, 2012 at http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010/.

Home Health Quality Initiative (2010). Fall Prevention: Best Practice Intervention Package. http://www.homehealthquality.org/hh/campaign/fallbpip/default.aspx

RESOURCES FOR CLINICIANS

Home Health Quality Initiative (2010). Fall Risk Assessment for Clinicians. See the video that demonstrates the TUG at: http://www.youtube.com/HHQualityImprovement

MAHC 10 - Fall Risk Assessment Tool

Click here to review the Validation Study of the Missouri Alliance for Home Care's fall risk assessment tool.

Conduct a fall risk assessment on each patient at start of care and re-certification.

Patient Name:_____

(Circle one) SOC or Re-certification Date:_____

Required Core Elements **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	**Points**
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis	
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level	
Incontinence Inability to make it to the bathroom or commode in timely manner Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling **Total**	

Clinician's signature_____

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Want resources to reduce your falls rate & compare yourself with other home care agencies? Join MAHC's Falls Reduction Benchmark Project – contact us today for more information!