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OF APPRECIATION

This hereby awarded to

DR. ANIAWANIS MAKHTAR

In recognition as
SPEAKER

PRE-CONFERENCE WORKSHOP FOR THE 3RD IIUM INTERNATIONAL CONFERENCE OF NURSING CONFERENCE 2023

11th of JULY, 2023
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IICoN 2023

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Fall Risk Assessment: It Starts with You

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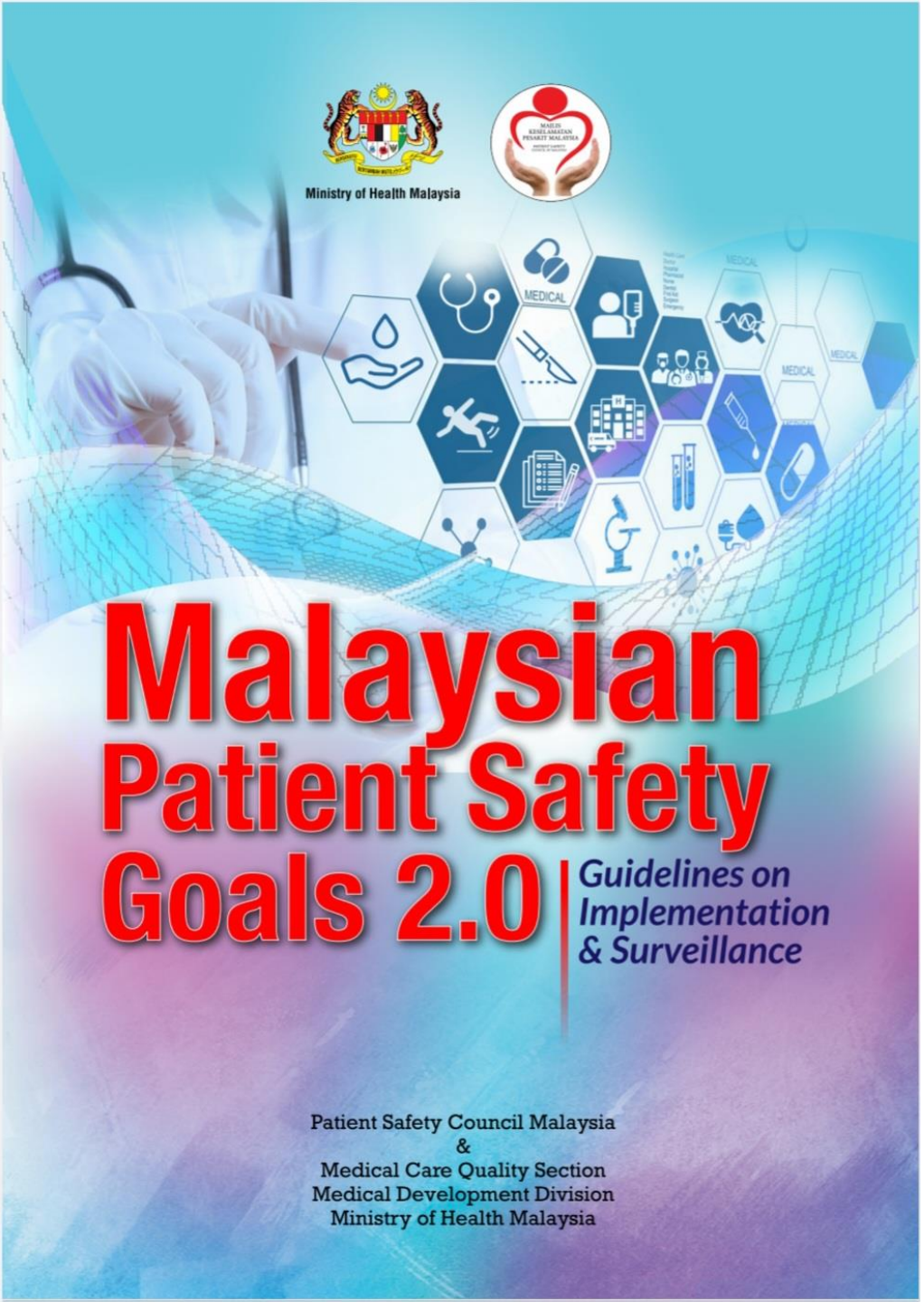


Malaysian Patient Safety Goals 2.0 Goal 5 - Patient Fall Prevention

Why fall prevention important in nursing?

- Patient fall has potential to cause severe harm. It can lead to prolong hospital stay, morbidity or even mortality.
- Patient fall is preventable with suitable safety measures such as safer environment, assessment of patient's risk and reducing the risk, close monitoring of patient.

Fall Risk Assessment

- Fall risk assessment is a critical component of patient safety in healthcare settings
- Nurses play a crucial role in:
  - Helps identify patients at risk for anticipated physiological falls
  - Provides basis for tailored or personalized care planning

Standardized Assessment Tool

- Use a standard assessment tool.
- Patients should be assessed for their fall's risks :
  - On admission
  - Upon transfer from one unit to another
  - With any status change
  - Following a fall
  - At regular intervals

- **Risk Assessment, Re-Assessment , Post-Fall Assessment**

Key Factors To Assess for Fall Risk

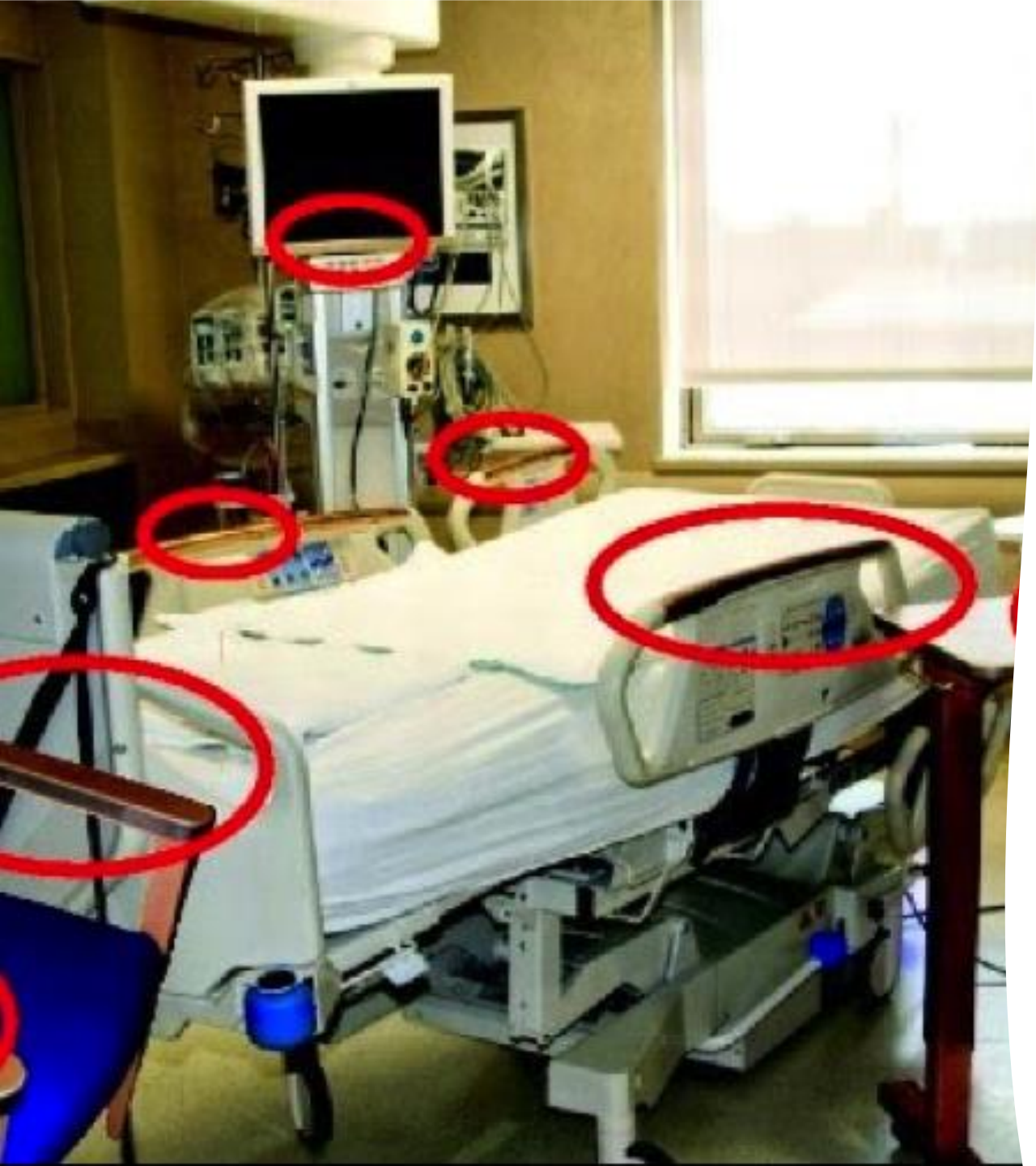
- History of falls
  - All patients with a recent history of falls in the past 3 months should be considered at higher risk for future falls.
- Mobility problems and use of assistive devices
  - Patients who have problems with their gait, or who use a cane or walker, are more likely to fall.

- **Assess patients' ability to use their assistive devices.**

Key Risk Factors for Falls

- Medications
  - Patients taking many medications that could cause sedation, confusion, impaired balance, or orthostatic blood pressure changes are at higher risk for falls.

- Mental status
  - Patients with delirium, dementia, or psychosis may be agitated and confused, putting them at risk for falls.



Key Risk Factors for Falls

- Continence
  - Patients who have urinary frequency, or who have frequent toileting needs, are at higher risk.
- Other risks
  - IV pole
  - Orthostatic hypotension
  - Oxygen tubing
  - Vision problems that cause patients to not see environmental hazards

Fall Risk Assessment Tools

- Tools to use:
- Morse Fall Scale
- Humpty Dumpty Fall Risk Assessment Scale
- Hendrich II Falls Risk Model
- Schmid Falls Risk Assessment Tool
- St. Thomas's Risk Assessment Tool (STRATIFY)

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	_____
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	_____
3. Ambulatory aid **None/bedrest/nurse assist** **Crutches/cane/walker** **Furniture**	 0 15 30	_____
4. Intravenous therapy/heparin lock	No 0 Yes 20	_____
5. Gait **Normal/bedrest/wheelchair** **Weak** **Impaired**	 0 10 20	_____
6. Mental status **Oriented to own ability** **Overestimates/forgets limitations**	 0 15	_____
Total Score: Tally the patient score and record. **<25: Low risk** **25-45: Moderate risk** **>45: High risk**		_____

Morse Fall Scale

- Rapid & simple method
- Widely used in acute care settings e.g. Malaysia
- Consist of six variables that are quick & easy to score:
  - History of falls
  - Secondary diagnosis
  - Ambulatory aid
  - IV/heparin lock
  - Transferring
  - Mental status

Morse Fall Scale

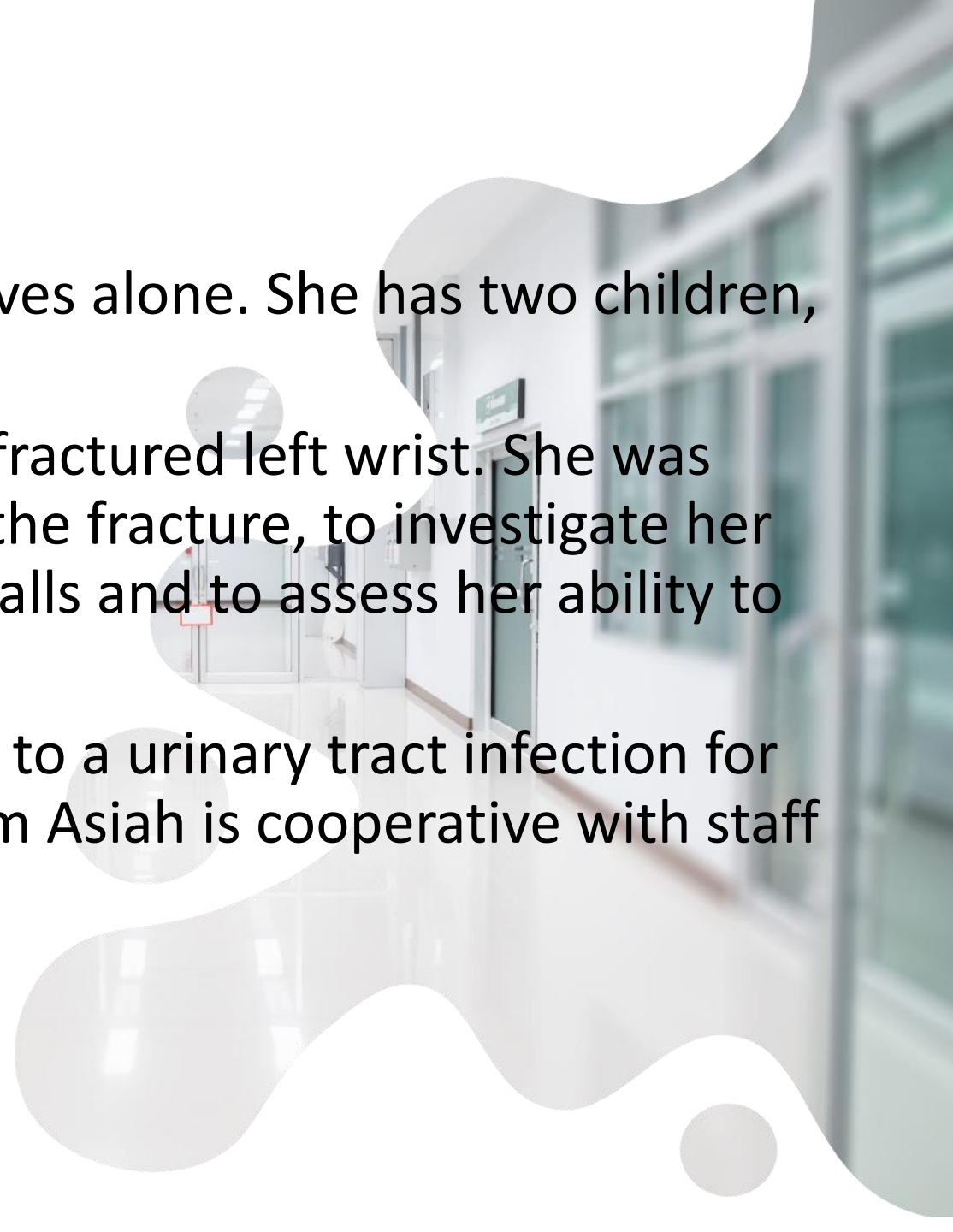
Scoring and Risk Level

The items in the scale are scored as follows:

History of falling	
25	If the patient has fallen during the present hospital admission or if there was an immediate history of physiological falls (eg. seizures or an impaired gait prior to admission)
0	If patient has not fallen
	Note: If a patient falls for the first time, then score immediately increases by 25
Secondary diagnosis	
15	If more than one medical diagnosis is listed on the patient's chart
0	None
Ambulatory aids	
0	If the patient walks without a walking aid (also if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all
15	If the patient uses crutches, a cane or a walker
30	If the patient ambulates clutching onto the furniture for support
Intravenous therapy	
20	If the patient has an intravenous apparatus or a heparin lock inserted
0	None
Gait	
0	For normal gait: walking with head erect, arms swinging freely at the side, and striding without hesitance
10	For a weak gait: patient is stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle
20	For impaired gait: patient has difficulty rising from the chair, attempting to get up by pushing on the arms of the chair or by bouncing (ie takes several attempts to rise). The patient's head is down, and he or she watches the ground. Poor balance, therefore the patient grasps onto the furniture, a support person, or a walking aid for support and cannot walk without this assistance
Mental status Check patient's own self-assessment of his or her own ability to ambulate by assessing the patient's response. Ask "Are you able to go the bathroom alone or do you need assistance?" Scored as:	
0	If the patient's reply in judging his or her own ability is consistent with the prior assessment, and patient is rated as 'normal'
15	If the patient's response is not consistent with the nursing orders or is unrealistic, of which the patient is considered to overestimate his or her own abilities and to be forgetful of limitations

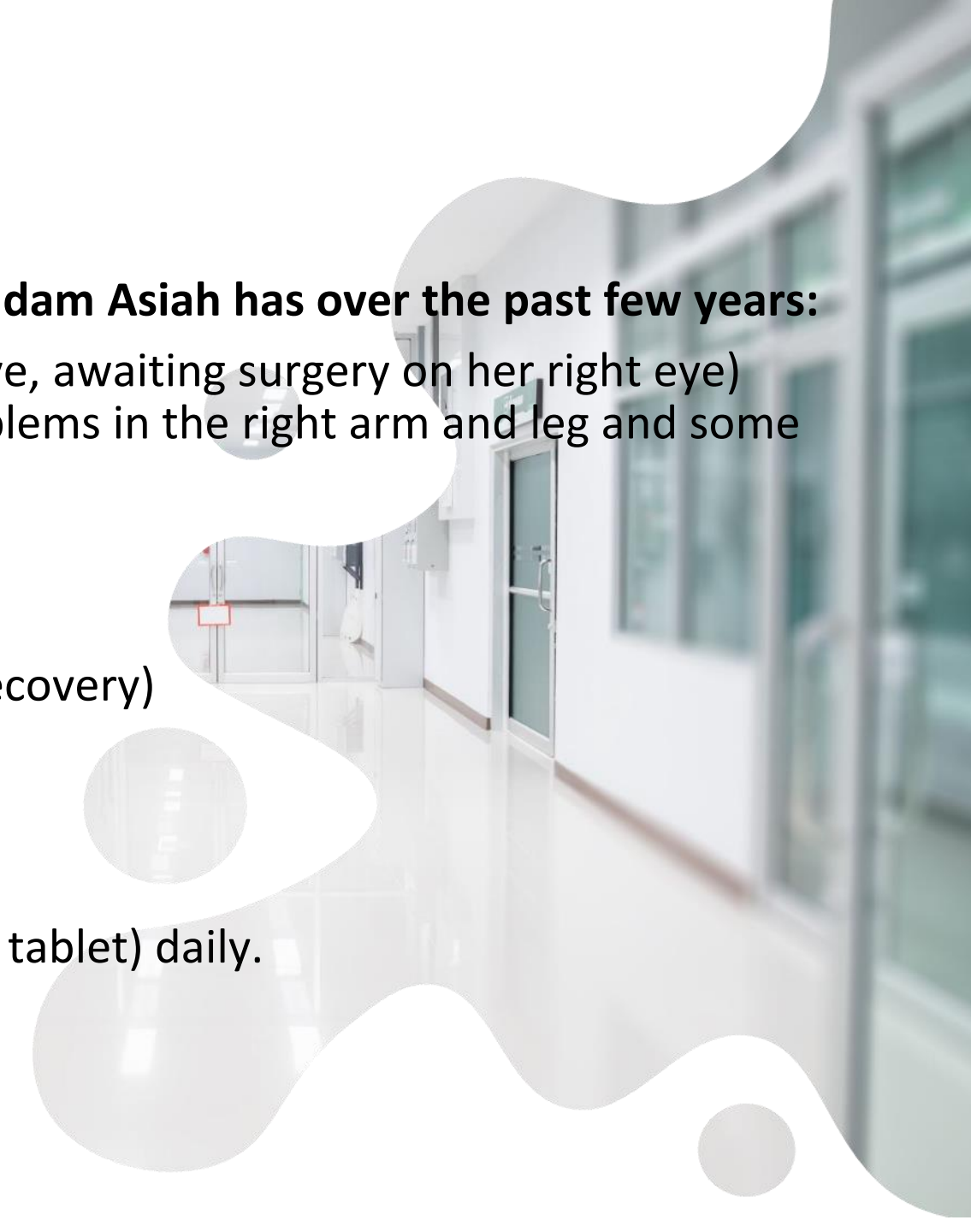
Case Study

- Madam Asiah is a 62-year-old lady who lives alone. She has two children, both of whom live in Kuala Lumpur.
- Madam Asiah fell at home, resulting in a fractured left wrist. She was admitted to hospital for management of the fracture, to investigate her recent increased memory problems and falls and to assess her ability to cope independently.
- Her recent confusion has been attributed to a urinary tract infection for which treatment has commenced. Madam Asiah is cooperative with staff instructions.



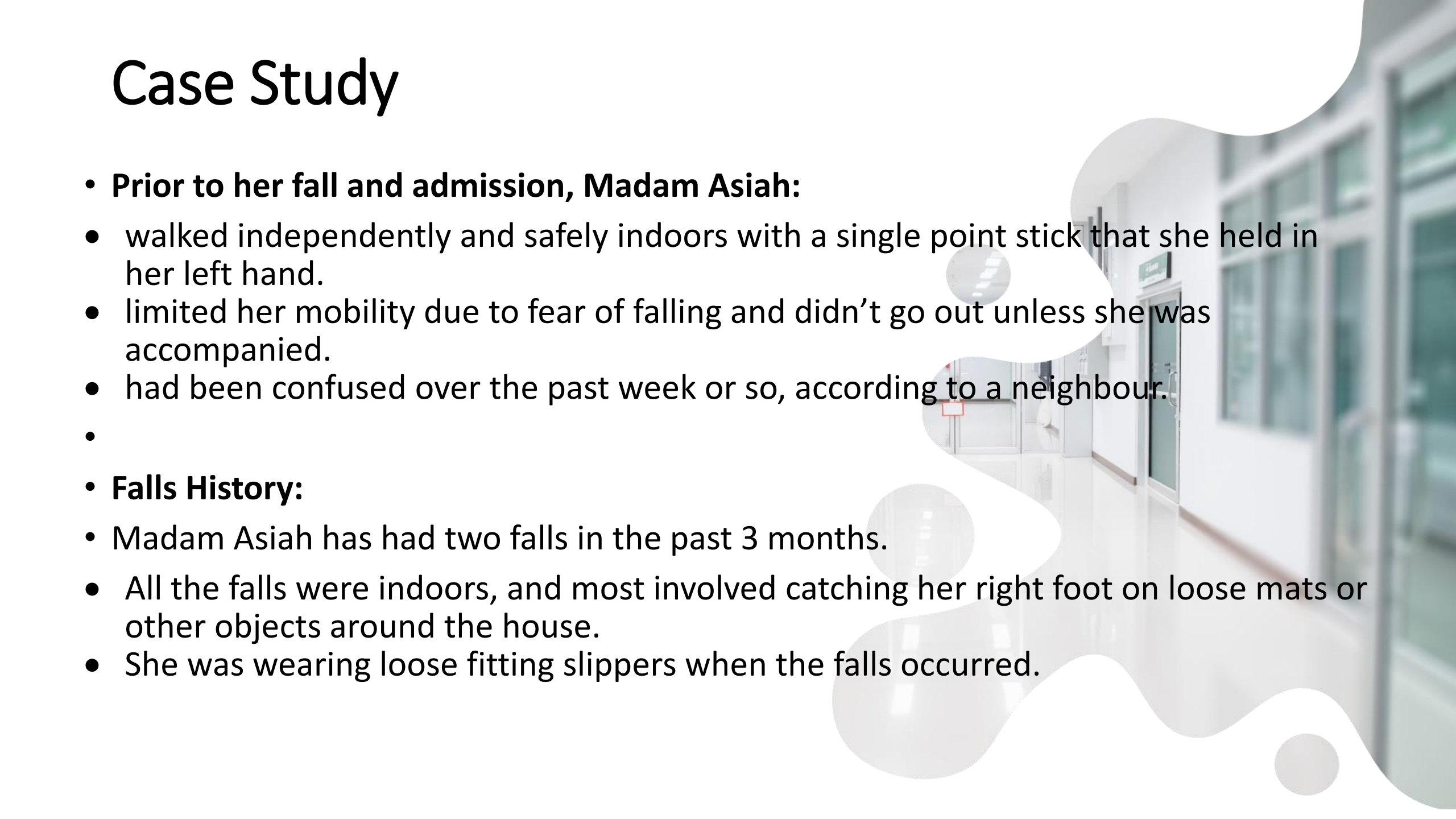
Case Study

- **The following are the list of medical conditions Madam Asiah has over the past few years:**
- cataracts (has had successful surgery on her left eye, awaiting surgery on her right eye)
- stroke (six years ago) causing mild movement problems in the right arm and leg and some memory problems.
- high blood pressure (controlled with medication)
- mild arthritis in both hips
- osteoporosis
- right total knee replacement 10 years ago (good recovery)
- diabetes (controlled with diet)
- urinary frequency
- high cholesterol
- wears bifocal glasses.
- seven prescription medications (including sleeping tablet) daily.



Case Study

- **Prior to her fall and admission, Madam Asiah:**
- walked independently and safely indoors with a single point stick that she held in her left hand.
- limited her mobility due to fear of falling and didn't go out unless she was accompanied.
- had been confused over the past week or so, according to a neighbour.
-
- **Falls History:**
- Madam Asiah has had two falls in the past 3 months.
- All the falls were indoors, and most involved catching her right foot on loose mats or other objects around the house.
- She was wearing loose fitting slippers when the falls occurred.



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Conclusion

- Fall risk assessment is an ongoing process that requires the active involvement of nurses and the collaboration of the entire healthcare team.
- By identifying and addressing fall risks proactively, nurses can significantly reduce the incidence of falls and enhance patient safety in healthcare settings.


Fall Prevention Is the Responsibility of All Healthcare Workers

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Thank you

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