Falls to Frailty Assessment:
A TRANSITION OF THINKING TO PRACTICE

Jon Buchan | Nurse Manager, Whanganui District Health Board
TOHU

Our tohu (symbol) depicts mother, father and child supported by extended family/whānau.

Whanganui DHB has adopted whānau ora as one of our key principles. The whānau ora approach is a patient-centred and family model of care.
DISCUSSION POINTS

- Our journey:
  - drivers for change
  - enablers
  - thinking

- Geriatric syndrome to frailty assessment

- Next steps
DRIVERS FOR CHANGE

- **2011**
  - National scoping of risk assessments in use in public hospitals

- **2013**
DRIVERS FOR CHANGE

• 2013 - 2017
  • Falls clinical lead visits to hospitals confirms challenges for nurses of conducting multiple risk assessments and repetitive questions of patients.
  • Emerging international evidence regarding the effectiveness/reliability of predictive risk assessment tools.
  • Data from quarterly national audits of falls process markers identified patients identified as being at risk not have care plans to manage those identified risks.
  • Release of the updated reducing harm from falls 10 topics by the HQSC.
THE ENABLERS

- The TrendCare programme capacity and staff familiarity with the system.
- Availability of mobile computers/wireless technology.
- Recognition of the number and time to complete risk assessments.
- Drive to hit the HQSC process marker targets.
- Nurses wanted less paperwork & more clinical time at the bedside.
TIME TO PAUSE...

and look at things differently...
NEW VISION FOR FALLS MINIMISATION EMERGED

1. Every patient needs to be either screened for falls risk, and/or have a completed detailed falls risk assessment if required.

2. Universal falls precautions implemented for every patient, making it safer for patients and staff in the hospital.

3. Individualised care plan must address the individual risk factors and be documented.

4. Allow easy auditing and data collection.
### FIRST STEP:
SCREENING ASSESSMENT FOR FALLS ONLY

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RESPONSE/SCORE</th>
<th>PROMPTS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Whanau Input</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient input</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and carer input</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls Screening</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Aged over 55 years and Maori or Pacific Islander</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Aged over 75 years in any ethnicity</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Patient has fallen in the past year</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Requires aids to mobilise?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clinical judgement suggests full assessment needed</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
## Detailed Falls Assessment

<table>
<thead>
<tr>
<th>Item</th>
<th>Response/Score</th>
<th>Prompts/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family/Whānau Input</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and care input encouraged</td>
<td>Yes/No/N/A</td>
<td></td>
</tr>
<tr>
<td><strong>History of Falls</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients most recent fall - <em>Single Selection</em></td>
<td>1/1/1/1</td>
<td>Cause of fall:</td>
</tr>
<tr>
<td>Pt admitted with a fall</td>
<td></td>
<td>Frequency of falls:</td>
</tr>
<tr>
<td>Pt fall within last 3 months</td>
<td></td>
<td>Injuries from previous falls:</td>
</tr>
<tr>
<td>Pt fall within last 3-12 months</td>
<td></td>
<td>Comment:</td>
</tr>
<tr>
<td>Pt fall one year or more ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history of falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable gait or looks unsafe walking</td>
<td>1/1/1/1</td>
<td>Is this new for the pt:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comment:</td>
</tr>
<tr>
<td><strong>Vision, Language and hearing deficit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt has hearing or visual deficits</td>
<td>1/1/1/1</td>
<td>Aides functional and appropriate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comment:</td>
</tr>
<tr>
<td>Pt requires aides ie. glasses or hearing aides</td>
<td>1/1/1/1</td>
<td>Aides functional and appropriate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comment:</td>
</tr>
<tr>
<td>Does Pt speak or understand English</td>
<td>1/1/1/1</td>
<td></td>
</tr>
<tr>
<td>Cognitive assessment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Pt has a communication impairment</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt has confusion, disorientation or memory loss</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Physiological causes been identified/excluded:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt is agitated, impulsive or unpredictable</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt over estimates / forgets limitations</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Does the pt have a neurological condition</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt has a fear of falling</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Continence</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pt has frequency, urgency or incontinence</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Has UTI been excluded:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pt on psychotropic or sedative drugs</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt on drug that may cause postural hypotension</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt take more than four drugs per day</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pt within 24hrs post anaesthetic/sedation</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Other Risks</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the patient have any other risks</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Please list other risks:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
UNIVERSAL PRECAUTIONS
FOR ALL PATIENTS

- safe footwear
- bed at the right height
- orientation to environment
- bed and wheelchair locked
- mobility aids & call bell within reach
- belongings within reach
- falls signalling system activated
- an uncluttered bed space
- have been warned of wet floors e.g. showers or spills
IMPACT OF IMPLEMENTATION

Positive
- Near 100% falls screening and/or full assessment.
- Universal precautions placed in the forefront of staff members’ minds.
- Individualised falls reduction strategies (care plans) implemented.

Negative
- Huge numbers of patients received screening and comprehensive fall assessments creating a two-step process.
- Removal of a score created a significant level of distress among nurses as to what strategies are best.
- Initial mourning of the loss of paper – some believed the electronic assessment took longer.
REALISATION

Why have two systems?

Same questions on many assessments.

One computerised assessment but many on paper.
LINKAGES
COMMON CONTRIBUTORY FACTORS

Care areas discussed:
- mobility
- continence
- nutrition
- medication
- vision
- cultural consideration
- home environment
- skin integrity

Risk factors requiring mitigation:
- pressure injury
- falls
- functional wellbeing
- support services required
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THE GERIATRIC & FRAILTY SYNDROME RELATIONSHIP

Geriatric syndrome
Health conditions common in elderly that are highly prevalent, multifactorial and often associated with morbidity and poor health outcomes include:

- falls
- pressure injuries
- incontinence
- functional decline
- delirium

THE GERIATRIC & FRAILTY SYNDROME RELATIONSHIP

Frailty syndrome

- Factors that place older adults at an elevated risk of decline in health and function.
- An agreed and accepted criteria for what constitutes a ‘frailty assessment’ is not yet clear cut with multiple models and concepts proposed.

THE GERIATRIC & FRAILTY SYNDROME RELATIONSHIP

Inouye et al (2007)

Shared risk factors

Geriatric syndromes
- Functional decline
- Pressure Injuries
- Falls
- Delirium
- Incontinence

Frailty

Poor outcomes
- Disability - dependence
- Nursing home
- Death
OUR VISION/THINKING

‘One nursing assessment completed for every patient.’

Meets the following concepts:

- covers all nurse-sensitive indicators of care
- not predictive/encourages critical thinking
- asks the question once
- prompts but does not dictate care requirements
- acknowledges the concept of complexity/‘geriatric syndrome’
- can affect many patients, but must be individualised.
## WHAKATAKEKATEAKE
### COMBINED NURSING ASSESSMENT QUESTION LOGIC

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pt able to mobilise unaided and without aids? &lt;**&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pt able to change position unaided without aids?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Headings**

- **Mobility**
  - Items Yes, no, N/A: Pt able to mobilise unaided and without aids? <**>
  - Prompt: Pt & family educated re risk of Pressure Injury?
  - Prompt: Changes in mobility discussed with family?
  - Action: Complete Mobility and Manual Handling Needs Assessment
  - Action: Pt at risk of pressure injury. Document strategy in patient care plan

- Items Yes, no, N/A: Pt able to change position unaided and without aids? <**>
  - Prompt: Pt & family educated re risk of Pressure Injury?
  - Prompt: Changes in mobility discussed with family?
  - Action: Complete Mobility and Manual Handling Needs Assessment
  - Action: Pt at risk of pressure injury. Document strategy in patient care plan
WHAKATAKAKE
NOW COVERS:

- mobility and manual handling
- nutrition (MUST)
- pressure injury (risk and current status)
- high risk of delayed discharges
- smoking cessation screening
- communication/language barriers
- cultural, religious and spiritual needs/supports
- continence
- pain (current and normal)
- cognitive consideration
- medication
- home environment

Acknowledgement: WDHB Kaumatua/māori elder John Niko Maihi for giving us the name for the assessment.
<table>
<thead>
<tr>
<th>Ward</th>
<th>AT&amp;R (Rehabilitation)</th>
<th>High dependency</th>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factor identified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall in the last year</td>
<td>42.42%</td>
<td>39.76%</td>
<td>31.06%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Unsteady Gait</td>
<td>30.30%</td>
<td>19.28%</td>
<td>20.45%</td>
<td>16.01%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>25.76%</td>
<td>13.25%</td>
<td>20.83%</td>
<td>9.27%</td>
</tr>
<tr>
<td>Fall and unsteady gait</td>
<td>21.21%</td>
<td>9.64%</td>
<td>14.02%</td>
<td>8.15%</td>
</tr>
<tr>
<td>Fall, unsteady gait and incontinent</td>
<td>10.61%</td>
<td>2.41%</td>
<td>5.68%</td>
<td>3.37%</td>
</tr>
</tbody>
</table>
QUALITY IMPROVEMENT

Percentage of patients seeking cultural support during their admission (April 2017)

- 41%
- 15%
QUALITY IMPROVEMENT

Percentage of patients seeking cultural support during their admission (April 2017)

- 41%
- 15%

Percentage of patients seeking cultural support during their admission (June 2017)

- 38%
- 62%
**NEXT STEPS:**
**BARIATRIC SUPPORTIVE MEASURES**

<table>
<thead>
<tr>
<th>Headings</th>
<th><em>Bariatric / obesity</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Items</td>
<td>Pt likely to need specialist equipment (BMI 35+) (*)+</td>
</tr>
<tr>
<td>Action</td>
<td>Order ‘Essential’ bariatric equipment (select hyperlink)</td>
</tr>
<tr>
<td>Hyperlink</td>
<td><a href="http://www.essentialhelpcare.org/bundles/bariatric">http://www.essentialhelpcare.org/bundles/bariatric</a></td>
</tr>
<tr>
<td>Action</td>
<td>Document body shape (see hyperlink)</td>
</tr>
<tr>
<td>Hyperlink</td>
<td>[K:\common\TRENDCARE\Assessment action file\Combinedassesment\Body Shapes.pdf](K:\common\TRENDCARE\Assessment action file\Combinedassesment\Body Shapes.pdf)</td>
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</tbody>
</table>