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**
  - Release of the National Institute for Health and Clinical Excellence (NICE) Falls Assessment and prevention of falls in older people: *www.nice.org.uk/guidance/cg161/evidence/falls-full-guidance-190033741*
  - Launch of NZ Health Quality & Safety Commission (HQSC) reducing harm from falls programme and development of evidence based 10 topics: *www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-topics/*

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...

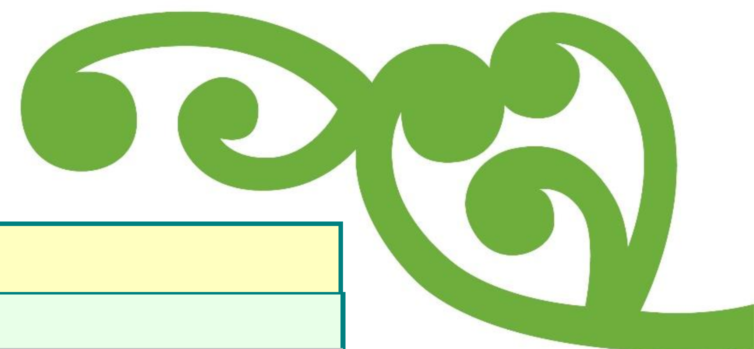
NEW VISION FOR FALLS MINIMISATION EMERGED

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

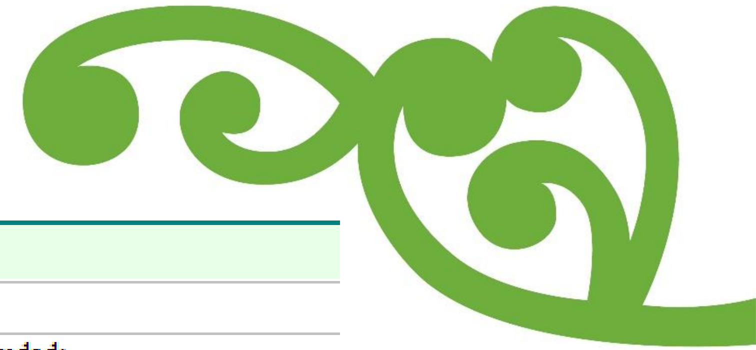
ITEM	RESPONSE/SCORE			PROMPTS/COMMENTS
Family/Whanau Input	Yes	No	N/A	
Patient input	☐	☐	☐	
Family and carer input	☐	☐	☐	
Falls Screening	Yes	No	N/A	
Aged over 55 years and Maori or Pacific Islander	☐ 1	☐	☐	
Aged over 75 years in any ethnicity	☐ 1	☐	☐	
Patient has fallen in the past year	☐ 1	☐ 1	☐	
Requires aids to mobilise?	☐ 1	☐	☐	
Clinical judgement suggests full assessment needed	☐ 1	☐	☐	

DETAILED FALLS ASSESSMENT



ITEM	RESPONSE/SCORE			PROMPTS/COMMENTS
Family/Whanau Input	Yes	No	N/A	
Family and care input encouraged	☐	☐	☐	
History of Falls	Yes	No	N/A	
Patients most recent fall - * Single Selection *				
Pt admitted with a fall	☐ 1			Cause of fall:
Pt fall within last 3 months	☐ 1			Frequency of falls:
Pt fall within last 3-12 months	☐ 1			Injuries from previous falls:
Pt fall one year or more ago	☐ 1			Comment:
No history of falls	☐ 1			
Mobility	Yes	No	N/A	
Unstable gait or looks unsafe walking	☐ 1	☐	☐	Is this new for the pt: Comment:
Vision, Language and hearing deficit	Yes	No	N/A	
Pt has hearing or visual deficits	☐ 1	☐	☐	Aides functional and appropriate: Comment:
Pt requires aides ie. glasses or hearing aides	☐ 1	☐	☐	Aides functional and appropriate: Comment:
Does Pt speak or understand English	☐	☐ 1	☐	

DETAILED FALLS ASSESSMENT



Cognitive assessment	Yes		No	N/A	
Pt has a communication impairement		1			
Pt has confusion, disorientation or memory loss		1			Physiological causes been identified/excluded: Comment:
Pt is agitated, impulsive or unpredictable		1			
Pt over estimates / forgets limitations		1			
Does the pt have a neurological condition		1			
Pt has a fear of falling		1			
Continence	**Yes**		**No**	**N/A**	
Pt has frequency, urgency or incontinence		1			Has UTI been excluded: Comment:
Medications	**Yes**		**No**	**N/A**	
Pt on psychotropic or sedative drugs		1			
Pt on drug that may cause postual hypotension		1			
Pt take more than four drugs per day		1			
Pt within 24hrs post anaesthetic/sedation		1			
Other Risks	**Yes**		**No**	**N/A**	
Does the patient have any other risks		1			Please list other risks:

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

Inouye et al (2007), Buta et al (2016)

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.

Talarska et al (2017), Buta et al (2016)

THE GERIATRIC & FRAILTY SYNDROME RELATIONSHIP

Inouye et al (2007)

Shared risk factors → Geriatric syndromes → Frailty → Poor outcomes

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**.

WHAKATAKETAKE

COMBINED NURSING ASSESSMENT QUESTION LOGIC

Mobility		
	Yes No N/A	Pt able to mobilise unaided and without aids?
	Yes No N/A	Pt able to change position unaided without aids?

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? <*>

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WHAKATAKETAKE

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

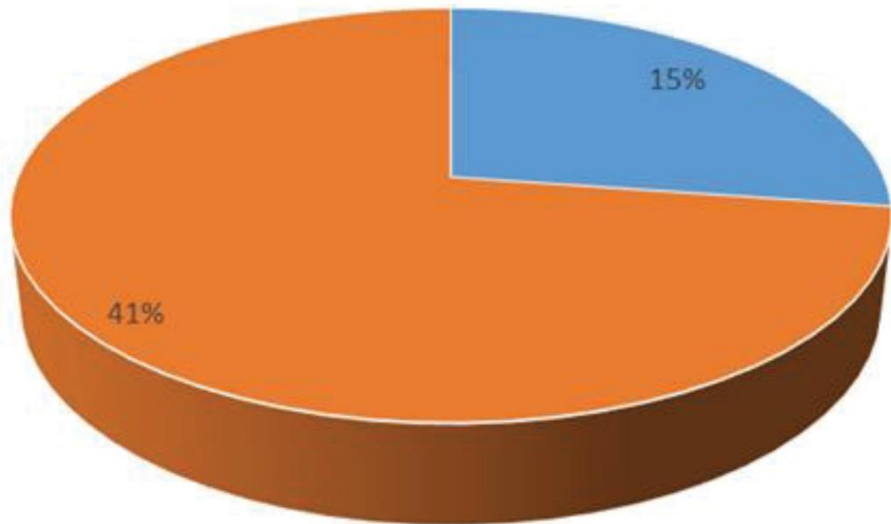
Acknowledgement: WDHB Kaumatua/māori elder John Niko Maihi for giving us the name for the assessment.

SOURCE OF RICH DATA

Ward Risk factor identified	AT&R (Rehabilitation)	High dependency	Medical	Surgical
Fall in the last year	42.42%	39.76%	31.06%	20.5%
Unsteady Gait	30.30%	19.28%	20.45%	16.01%
Incontinence	25.76%	13.25%	20.83%	9.27%
Fall and unsteady gait	21.21%	9.64%	14.02%	8.15%
Fall, unsteady gait and incontinent	10.61%	2.41%	5.68%	3.37%

QUALITY IMPROVEMENT

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



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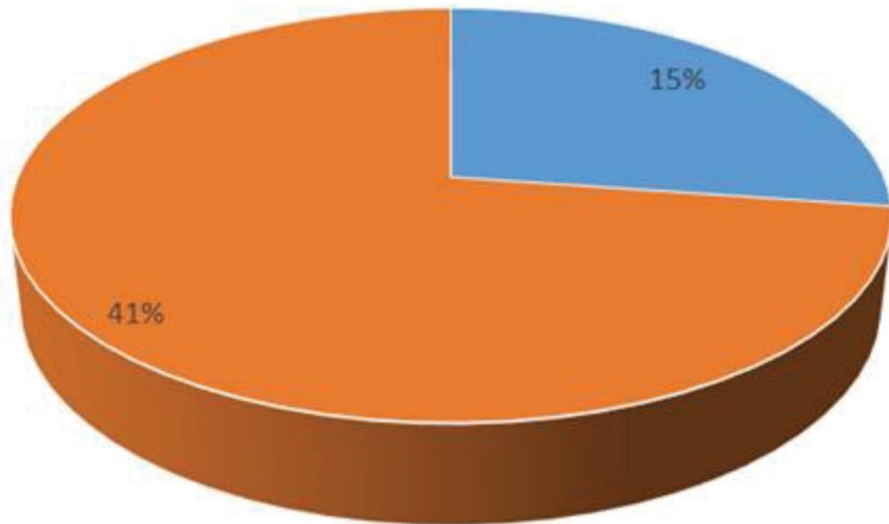
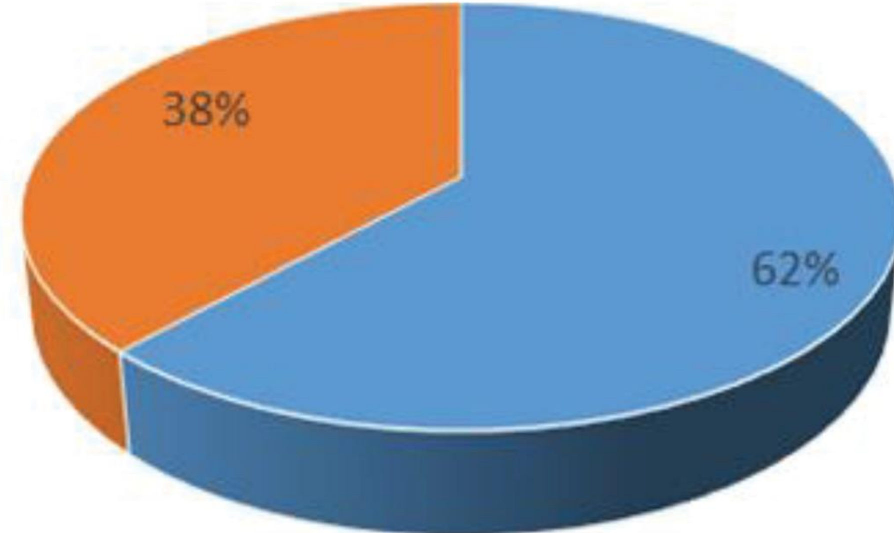


Percentage of patients seeking cultural support during their admission *(June 2017)*



NEXT STEPS:
BARIATRIC SUPPORTIVE MEASURES

Headings	: **Bariatric / obesity**
Items Yes, no, N/A	: Pt likely to need specialist equipment (BMI 35+) (*)+
Action	: Order 'Essential' bariatric equipment (select hyperlink)
Hyperlink	: http://www.essentialhelpcare.org/bundles/bariatric
Action	: Document body shape (see hyperlink)
Hyperlink	: K:\common\TRENDCARE\Assessment action file\Combinedassesment\Body Shapes.pdf

WHANGANUI
ALL YOU NEED (AND THEN SOME)