Risk assessment helps prevent falls in ACS patients

Anyone undergoing surgery is at heightened risk of falling, especially during recovery from sedation, and for the most vulnerable patients, a fall can be disabling or even deadly.

Falls are among the adverse events monitored by the Centers for Medicare and Medicaid Services and state surveyors. The science of assessing fall risk has advanced in recent years, focusing mostly on inpatients and those in long-term care facilities, while outpatients have been assumed to be healthier and therefore at less risk.

Even so, ambulatory surgery centers (ASCs) are looking for ways to keep their patients safe from falls and, more importantly, safe from injury. ASC patients may be at risk from a number of factors: medications, age, and surroundings such as obstacles and uneven floors. They also face risks associated with surgery.

**Strategies from the VA**

According to the ASC Quality Collaboration Quality Report for the third quarter of 2012, ASCs nationally reported a patient fall rate of 0.134 per 1,000 admissions. The report covers 1,381 ASCs with a total of 1,477,319 admissions, or 198 falls.

Despite a healthier patient population, ASCs face 2 risks that differ from those in hospitals: Nearly all of their patients undergo surgery, and therefore anesthesia or sedation, and until now, ASCs rarely had procedures in place for assessing and managing fall risks.

The Department of Veterans Affairs (VA) categorizes fall risks as either extrinsic (external to the patient) or intrinsic (internal, belonging to the patient). Extrinsic risks might include low lighting, clutter, spills, medication, and loose electrical cords. Internal risks are contained within the patient, and could include muscle weakness, poor vision, chronic disease, low blood pressure, and balance problems.

The VA uses the Morse Fall Scale to assess its acute and long-term care patients. The scale grades 6 factors:
- previous falls
- secondary diagnosis
- ambulatory aid such as a cane
- IV or heparin lock
- impaired gait
- mental status.

Based on the severity of each factor, the clinician compiles a score ranging from 0 to 51, with 0 to 25 indicating low fall risk, 25 to 45 a moderate risk, and higher than 45 a high risk.

Now, the VA is transferring that knowledge to outpatients. Pat Quigley, PhD, is associate director of the Veterans Integrated Service Network (VISN 8) Patient Safety Center of Inquiry at the James A. Haley VA Medical Center in Tampa, Florida. She administers fall prevention clinics for at-risk VA patients. Following a consultation with the patient, the clinic staff creates a treatment plan. “We give them the knowledge and skills to be safer,” Quigley says.

The experience has given her insight into what is most likely to cause falls. “The
number 1 indicator of fall risk is a history of previous falls,” she says. “It’s a marker that other things are going on.”

Specific risks that might apply to ASC patients include:

• old age, because of associated conditions like declining vision and diabetes
• irregular heartbeat, which may cause fainting or blackout; the screener should ask, “Have you fainted before?”
• low blood pressure; the screener should ask, “Do you get dizzy when you stand up?”
• certain diagnoses, such as stroke and diabetes, due to loss of feeling in the feet
• medications and interactions, especially anticoagulation drugs
• osteoporosis of the hips
• sedation after surgery.

For ASC patients, the admission interview is likely the first and best opportunity to identify fall risks. In that context, Quigley advises, address the immediate circumstance. Help patients avoid falls by warning them, and their families or escorts, that they will be unstable. Explain that staff will be with them at all times after the procedure.

ASCs can reduce environmental risks for all patients, she adds, by installing raised toilet seats and railings. She and others note that a large percentage of falls occur when a patient feels an urgent need to use the toilet, forgetting the effects of sedation on their balance and reflexes.

“Create a safe environment that is elder friendly,” Quigley says.

While inpatients at risk of falling often are given colored armbands or slippers, Quigley notes that ASCs need to consider all their patients as fall risks. They should make wheelchairs available and alert staff to the need for surveillance and patient education.

Although it may be impossible to prevent all falls, the main goal should be to prevent injuries. The Centers for Disease Control and Prevention reports that for people over age 85, the number 1 cause of death is falling. The reason is head injuries, which can lead to bleeding and complications such as infection.

If a patient starts to fall, the caregiver should first protect the head, Quigley advises. “You can’t always catch them, and a staff member could be hurt trying,” she says, “so focus on the head: You always want to protect the head on the way down.”

Statewide survey
In 2012, the Minnesota Hospital Association (MHA) surveyed members to learn how they screen outpatients for fall risk and what preventive measures they use.

That year’s annual adverse event report showed that 79 falls had occurred at hospitals and ASCs in Minnesota, an increase of 11% from 2011. Six patients died as a result of falling. The most common injuries from falls were hip fractures, upper or lower extremity fractures, and head trauma.

Although most of those falls occurred in inpatient settings, MHA wanted to learn more about outpatient fall management, according to Julie Apold, senior director of patient safety. She and her staff worked with Quigley to assess the survey results and develop strategies to avoid outpatient falls.

The best strategy in the outpatient setting, Apold concludes, is to identify patients at risk of falling as early as possible. “If we can identify them early, we can put interventions in place to prevent them from falling or from being injured if they do fall.”

The Minnesota survey showed hospitals were aware that all surgery patients, including outpatients, are susceptible to falls, and that age is a good predictor of falling. Other conditions to consider were confusion, dizziness, recent falls, inability to walk, and seizures.
The most frequent interventions against outpatient falls were helping the patient out of the car and assistance with all activities: walking, wheelchair use, dressing, and using the bathroom. Patients and their escorts were warned about the potential for falls and the need for assistance.

**The Hartford experiment**

An incident in 1 of Hartford (Connecticut) Hospital’s 2 owned ASCs triggered an effort to reduce the number of falls among outpatients. After a patient with multiple sclerosis fell, the ASC asked for guidance in preventing further falls. Because the hospital had protocols designed only for inpatients, a group was appointed to try to adapt those protocols for outpatient use. ASCs, in addition to other outpatient units such as radiology and oncology, participated.

“The goal was to develop a risk assessment form that would be applicable to all outpatients,” explains Cheryl Larsen, BSN, RN, nurse manager of pre- and postoperative care.

One of the first things they learned was that clinicians perceived outpatients as healthier and therefore at less risk of falling. In a 3-year period, however, there were 143 falls with 40 injuries in the hospital’s outpatient facilities.

In addition, outpatient units had less information than was available in the main hospital. “For instance,” Larsen notes, “if you first see a person on a stretcher, you don’t know if they use a cane.”

They developed a questionnaire to screen all outpatients for a history of falls, confusion, and impaired mobility, and they included some variation in the questions based on the type of outpatient treatment received.

In 2010, the group introduced the new screening form to Hartford Hospital’s outpatient staff, and it has continued to track fall and injury rates. At the same time, it mandated new fall-prevention practices for outpatients. These include:

- green wristbands for high-risk patients
- patient and family education
- assistance with all patient transfers
- assistance with dressing or undressing
- bathroom assistance and supervision.

While falls have not been entirely eliminated, Larsen says the group is encouraged by the increased awareness of fall risks and efforts to implement the recommendations. Reporting of falls has increased, she says, and staff are more active in prevention, even asking for additional coverage for patient assistance when necessary.

—Paula DeJohn