

# Falls Prevention Toolkit for DSH Clinical Teams



This toolkit serves as a broad clinical guide. Its purpose is to ensure standardized safety and care. The protocols in this toolkit are applicable across a wide variety of settings within the Department of State Hospitals (DSH) and its community partners.

## Educate Patient and Family

Empower patients to take an active role in their own safety.

### Movement and Mobility

- Take time when moving from a lying to a sitting or standing position to prevent dizziness
- Avoid using furniture for support (do not lean on bedside tables, or tray tables)
- Make staff aware when planning to get out of bed (e.g., call light, bell, sitter)

### Safety Gear

- Wear non-slip socks or sturdy, non-slip footwear at all times
- Wear well-fitting clothing and footwear
- Use walkers or canes if approved by the clinical team
- Use non-slip spray or stickers in shower area to avoid falls during hygiene and Activities of Daily Living (ADLs)

## Ensure Environment is Safe

Proactive measures to minimize environmental hazards.

### The Reach Test

- Ensure the call light, phone, water, and tissues are within a patient's immediate reach, especially at night

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## Observation & Placement

- Place high-risk patients near the nurse's station
- Utilize alarms for medically compromised or high-risk patients
- Increase observation for patients who are sedated, confused, elderly or undergoing detoxification

## Other Measures

- Keep the room and the path to the bathroom completely clear of clutter and promptly clean any spills
- Provide safety devices in patient bathrooms (e.g., grab bars, non-slip flooring, etc.)
- Keep bed height low and/or at height with wheelchair
- Use fall-risk indicators (e.g., previous fall, gait, balance and walking problems, multiple medications, positional low blood pressure, feet and ankle issues, vision impairment) directly on door frames and within patient's chart
- Maintain proper lighting in all patient areas
- Redirect rapid pacing in crowded areas
- Encourage frequent rest breaks for highly activated or restless patients
- Implement routine rounding every 15-30 min and encourage regular toileting
- Utilize hospital bed alarms specifically for medically compromised patients or those with a significant risk of falling

## Consider the Role of Medications

- Review all medications to stop, switch, or whenever possible reduce dosages for those medications that increase fall risk
- Monitor patients closely after starting or increasing antipsychotics, benzodiazepines, mood stabilizers or sleep medications
- Schedule sedating medications at bedtime whenever possible
- Evaluation for orthostatic hypotension
- Encourage patients to sit at the bedside for a moment after taking medications before attempting to stand
- Optimize management of diabetes, hypertension, osteoporosis, and urinary incontinence
- Limit multiple vaccinations at one time and observe patient after vaccinations

## Leverage Rehabilitation Services

- Implement programs like the [Otago Exercise Program](#), progressive resistance training, or Tai Chi to improve balance and strength
- Encourage and monitor for use of vision and hearing corrections
- Consult podiatry for foot health as necessary

- Ensure proper fit and use of assistive devices (walkers/canes)
- Train staff to recognize gait and posture changes that indicate a fall risk and how to intervene effectively (can be done using the STEDI Protocol listed below).

## Communicate with Clinical Team Members

- Document all instances of gait instability or dizziness immediately
- Utilize standard communication methods (e.g., huddles or shift reports) to ensure all staff are aware of high-risk patients
- Conduct environmental and home safety assessments and/or discuss with individuals support system (family, social worker)

## Clinical Assessment: The STEADI Protocol

### Screening

STEADI begins with three key screening questions that should be asked annually and after a fall:

1. Do you feel unsteady when standing or walking?
2. Do you worry about falling?
3. Have you fallen in the past year?

An affirmative answer to any of these questions indicates the need for further evaluation.

### Functional Assessment

Further evaluation includes three functional tests to evaluate gait, strength, and balance:

- **Timed Up and Go (TUG) Test**

The patient stands from a chair, walks 10 feet at their regular pace, turns around, walks back, and sits down. Completion in 12 seconds or more indicates increased fall risk.

- **30-Second Chair Stand Test**

The patient sits in a chair with arms crossed over the chest and stands up and sits down repeatedly for 30 seconds. The number of repetitions is counted, with lower numbers indicating higher risk (age-specific cutoffs apply; for example, fewer than 11 stands for men aged 75-79 or fewer than 10 for women in this age group).

- **4-Stage Balance Test**

The patient holds four progressively difficult positions for 10 seconds each: (1) feet side-by-side, (2) one foot halfway forward with instep touching the big toe of the other foot, (3) tandem stance with heel touching toes, and (4) standing on one foot. Inability to hold position 2 or 3 for 10 seconds, or inability to stand on one leg for 5 seconds, indicates increased fall risk.

## Evidence and Implementation

Implementation of STEADI in primary care has demonstrated effectiveness, with one large cohort study showing that older adults at risk for falls who received a Fall Plan of Care were 0.6 times less likely to have a fall-related hospitalization compared to those without such a plan. The US Preventive Services Task Force references STEADI as a key resource for fall prevention in community-dwelling older adults.

## References

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