

## Taking a Person-Centered Approach to Fall Management

Pennsylvania Association of County  
Affiliated Homes  
Fall 2011 Conference

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## Fall facts

- One year post fracture, only 25% of people over 65 regain their former functional status (Legters, K. 2005)
- Falls cause loss of confidence in ability to function safely and the result is fear of falling.
- 50% of people who have fallen admit to restricting normal activities leading to periods of immobility.
- Decreased activity leads to increased complications such as :
  - Muscle weakness
  - Osteoporosis
  - Decreased socialization and depression
  - Increased fall risk

(Koot, R. 2009)



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## Post-Fall Mortality

- Falls are the leading cause of fatal and non-fatal injuries to people over 65 (Kung, 2008)
- "Between 18%-33% of older hip fracture patients die within one year of their fracture" (Kung, 2008)



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### Financial Impact of Falls

- Clinical care following a fall= \$9,100- 13,500 (average)
  - Diagnostic procedures
  - Need for more staffing hours
  - Poor public relations and reputation
  - Impact on Five- star rating
  - Increased legal expenses
  - Potential issues related to reimbursement for care if determined it was a preventable serious adverse event (PSAE)

(D. Sheridan , "Investigation of Accidents and Falls" AANAC conference 4/2009)



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Fall risk is more than just a "high risk" score...



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It takes improving process to achieve better outcomes



From The Team Handbook



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### Changing fall management process

- Assemble an interdisciplinary team.
- Establish team goals.
- Plan team strategies.
- Provide time and resources for team to utilize.
- Team trains all staff.
- Empower leaders throughout facility.



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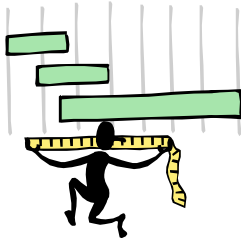
### Select performance measures

Set goals for measures:

A **SMART** goal is:

- specific
- measurable
- attainable
- relevant
- time based

**A goal that is very clear and easily understood.**



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### Fall data

- Determine data collection tools:
  - Train personnel who will collect data
- Collect data
- Analyze data and review results
  - Compare with historical data for trends
  - Examine for patterns



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### Fall management team

- Who's involved? (CNA, housekeeping, dietary, etc)
- Are we meeting enough?
- Do we track and trend falls?
- Are we taking an educational and leadership role in fall management?
- What happens when a fall occurs?
- How do we communicate with staff, residents, families, other care providers?
- What do we need to improve?



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### The "keys" to success

- Consistent care assignments
- "Champion" the cause
- Educate, educate, educate
- Improve assessment process
- Strengthen post-fall investigation
- Identify root cause of fall
- Communicate with physician, family, residents and staff
- Coordinate with care plan process



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### The most important step to changing any care process:

- Focusing on **resident centered** assessment to determine the most appropriate **individualized** interventions
  - Facilitates the development of *critical thinking* skills for the staff
  - Eliminates "cookie-cutter" care plans
  - Ensures the development of a care plan that will allow the resident to achieve or maintain their highest level of functioning



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### The Generic Plan of Interventions

- Personal alarms chair and bed
- Low beds, fall mats, perimeter mattress
- Keep call bell in reach, remind to use
- Keep room free of clutter
- Keep items in easy reach
- Non-skid footwear
- Adequate lighting
- Toileting program
- Frequent monitoring/safety checks



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### Hierarchy of Actions and Interventions

National Center for Patient Safety

- Weak- actions that depend on staff to remember their training or what is in a policy or procedure
- Intermediate- actions somewhat dependent on staff remembering to do the right thing, but provide tools to help staff remember
- Strong - actions that do not depend on staff to remember to do the right thing, may not totally eliminate vulnerable situation but provides very strong controls



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Alarms are not the answer!



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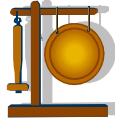
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### Negative outcomes related to alarms

- Staff respond to the alarm, and not the resident's unmet needs
- Create noise, confusion = increased agitation
- Staff desensitized to sounding alarms
- May not work as intended
- May increase fall risk
- Dignity issues
- Survey deficiencies



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### Time to think outside the box



dreamstime.com

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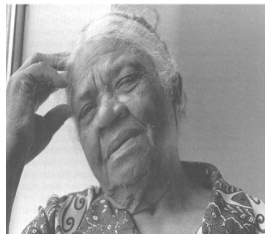
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### Meet Emma

- Age 91 admitted to nursing home from assisted living on 9/13/10 due to increased falls. Described as confused at times, impulsive and very independent. Pleasant, quiet, likes her "space." Likes to be in her room. Family very involved. Assist of one for transfers and ambulation with walker and w/c long distances. Incontinent of bladder at times, continent of bowels. Able to use call bell but does not.



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## Emma

- Emma is a widow, her husband passed away in 1999. They were married for 55 years and had two sons and two daughters. All family lives within one hour radius of the nursing home. Emma has multiple grandchildren and great grandchildren. She was a homemaker and worked part time in an elementary school cafeteria. She planted flowers; she grew and canned vegetables; Emma was an active church member, who sang in the choir, was the back-up organist, and organized many church events and fundraisers. Baking and cooking were favorite past-times. Emma used to sew. Her family relates that she also painted, not on canvas- but she frequently painted both the inside and outside of her house.




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| FALL RISK ASSESSMENT               |                                      | ASSESSMENT DATE: _____ |  |
|------------------------------------|--------------------------------------|------------------------|--|
| 1. LEVEL OF MOBILITY               | 2. ALBPT - UNABLE TO GET COMFORTABLE |                        |  |
| 3. HISTORY OF FALLS                | 4. UNABLE TO GET COMFORTABLE         |                        |  |
| 5. ELIMINATION HISTORY             | 6. UNABLE TO GET COMFORTABLE         |                        |  |
| 7. GAIT/BALANCE                    | 8. UNABLE TO GET COMFORTABLE         |                        |  |
| 9. BLOOD PRESSURE                  | 10. UNABLE TO GET COMFORTABLE        |                        |  |
| 11. MEDICATIONS                    | 12. UNABLE TO GET COMFORTABLE        |                        |  |
| 13. PREEXISTING MEDICAL CONDITIONS | 14. UNABLE TO GET COMFORTABLE        |                        |  |
| 15. VISION                         | 16. UNABLE TO GET COMFORTABLE        |                        |  |
| 17. HEARING                        | 18. UNABLE TO GET COMFORTABLE        |                        |  |
| 19. COGNITION                      | 20. UNABLE TO GET COMFORTABLE        |                        |  |
| 21. PSYCHOLOGICAL                  | 22. UNABLE TO GET COMFORTABLE        |                        |  |
| 23. SOCIAL                         | 24. UNABLE TO GET COMFORTABLE        |                        |  |
| 25. TOTAL SCORE                    | 26. UNABLE TO GET COMFORTABLE        |                        |  |

### Intrinsic risk factors

Those factors that originate with the individual or within the individual and include:  
 -Normal changes of aging  
 -Disease processes




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## Emma's Extrinsic Risk Factors



**New Environment-**  
 What is Emma sitting in all day?

**New caregivers-** Consistent or a new face every day?



**New Routine-** Is the routine directed by Emma or the staff?




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### Emma's Intrinsic Risk Factors

- Post CVA 2010 with residual mild left hemiparesis
- DM- Type 2
- CAD
- PVD
- Hypertension
- Depression
- Osteoarthritis
- DJD
- Gout
- CHF
- Post right mastectomy 2008
- Osteoporosis
- S/P pneumonia November/2010




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### Emma's Intrinsic Risk Factors (continued)

- Zolof 50 mg po HS
- Multivitamin QD
- ASA 81 mg am QD
- Cardiazem 60 mg qid
- Metoprolol 50 mg bid
- Accupril 20 mg QD
- Digoxin .25 mg QD
- Folic Acid 1 mg QD
- Allopurinol 200 mg QD
- Miacalcin nasal spray to alternating nostrils QD
- Tylenol 650 mg q4 hours prn




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### Initial fall prevention care plan

- Remind resident to use call bell
- Provide walker and one assist for transfer/ambulation and w/c for longer distances
- PT
- Keep call bell in reach
- Place frequently used items near resident
- Provide non-skid footwear
- Provide adequate lighting
- Low bed
- Eliminate clutter
- Maintain furniture pattern




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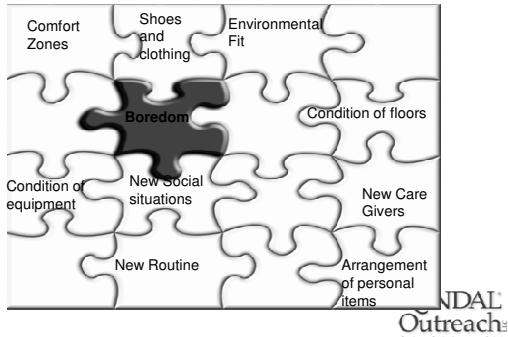
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### What pieces need to be included from the beginning?




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### Emma's Falls

- 9/22/10 6:30 AM Found on floor by bed, tripped on electric cord from under the bed.
- 9/28/10 12:30 AM Found on floor by bed, "I thought it was time to get up." Clip alarm applied.
- 10/10/10 10:30 AM Found on floor by bed, transferring self from w/c back into bed. Resident had removed clip alarm.
- 11/1/10 5:45 AM Found on floor near bathroom door. Using over the bed table as "walker." Alarm did not sound; resident had removed gown.




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### Falls (continued)

- 12/5/10 10:00 AM Laying on floor by closet, stood from w/c to retrieve sweater. Removed clip alarm.
- 12/19/10 7:10 AM On floor by window, "I was turning the heat up."
- 12/22/10 5:50 AM On bathroom floor. "I had to go." Clip alarm found under resident's bed. "I don't like that noise, I don't want it near me. I will call the police if you put it back"




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### Additions to initial care plan

- Secure electric cord to bed frame with plastic tie (9/22/10)
- Clip alarm (9/28/10)
- Q 2 hours toileting schedule (11/1/10)
- Psyche consult (12/22/10)




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### Post-Fall Investigation/Assessment



- Questions to ask
  - Date of last fall and circumstances?
  - Changes in meds in the last 30 days?
  - Other changes in orders in the last 30 days?
  - Any changes in mood/behavior in the last 30 days?
  - Any changes in function in the last 30 days?
  - Any new or acute conditions?

ESI- Nursing Home (Event Scene Investigation)




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### Post-Fall investigation assessment (continued)

- List recent abnormal lab values
  - Are labs up to date?
- Review of documentation related to the fall
- If witnessed, statement of the witness
- Vital signs and how they compare to baseline
- Review of documentation (nurses notes, therapy, social services) for the seven days prior to the event
- Review care plan- do the interventions in place address risk factors?




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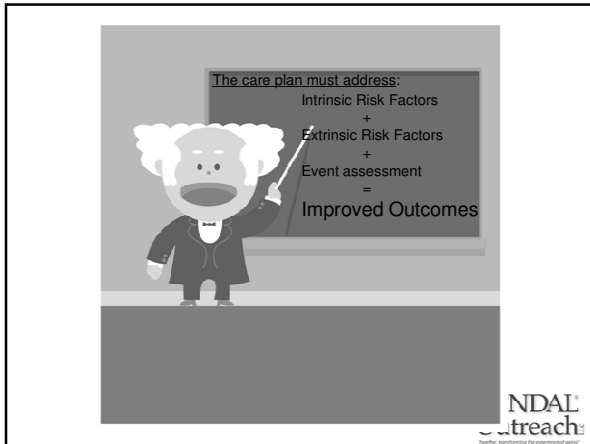
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**New interventions to address extrinsic risks and specific event.**

- 9/28/10 Illuminated, large clock.
- 10/10/10 Assess for safe bed transfer height, mark the wall behind the headboard with tape to cue staff to maintain this height
- Automatic brakes on the wheelchair
- 11/1/10 Try an alarm that plugs into call bell system to eliminate the noise that is disturbing
- Initiate a call cord that is illuminated or wrap the cord with craft tape. Make it easier for her to locate.
- Initiate 5:30 AM and 6:30 AM check to see if she is awake and offer toileting
- 12/5/10 Remove the high bar in her closet. Put shelving in the closet so that she can easily access her things.

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**New interventions (continued)**

- 12/19/10 Check the room temperature.
- Provide additional blankets in easy reach for the resident.
- 12/22/10 Anti-skid tape or anti-skid mat on the bathroom floor
- Assess BR to make sure there are enough assist bars and that they are not loose.



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### New interventions to address intrinsic risk factors

- Check BP lying, sitting & standing at least one minute apart, bid for a minimum of three days
- Pain assessment (remember neuropathic pain feels like electrical shocks, pins and needles and is treated with antidepressants and or anti-seizure medications)
- Blood sugar at the time of the fall
- Pulse ox level at the time of the fall
- Support bra/ appropriate prosthesis
- Hip protectors related to osteoporosis
- Aqua socks



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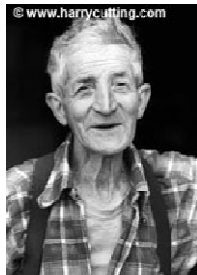
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### In conclusion...

- Build an effective fall management team
- Look for root causes
- Use person-centered approaches
- Each identified risk factor needs corresponding care plan intervention
- Never stop assessing and trying new interventions



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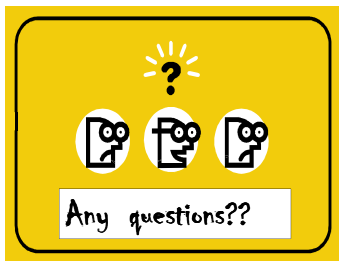
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### Contact Information

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