Falls Management In the Dementia Population: An Interdisciplinary Approach
Presented by
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PREMIER THERAPY

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OBJECTIVES

1. Discuss the financial, physical, and psychological impact of falls for the older adult.

2. Describe the fundamentals of balance and specific issues for the dementia patient.
OBJECTIVES (continued)

3. Identify patient specific strategies based on physical performance and cognitive level to address falls.

4. Design an interdisciplinary approach using evidence-based interventions for falls prevention in the dementia population.
PREVALENCE OF FALLS

25% of people aged 65 and older fall each year (Approximately 1 out of 4 people)

• 1 out of 5 falls result in serious injury
• 3 million older adults are treated in the ER for falls
• Over 800,000 adults are hospitalized because of a fall each year (head injury and hip fractures).
PREVALENCE OF FALLS

- 1 fall can double your chance of falling again.
- More than 95% of hip fractures are due to falls.
- Falls are the most common cause of TBIs.
- Falls are the leading cause of injury, hospital admissions, and death in people 65 years and older.
CDC Estimates Fall Deaths

Fall Death Rates in the U.S.
INCREASED 30%
FROM 2007 TO 2016 FOR OLDER ADULTS

If rates continue to rise, we can anticipate
7 FALL DEATHS EVERY HOUR BY 2030

Learn more at www.cdc.gov/HomeandRecreationalSafety.
COST OF FALLS

• In 2015, the Total Medical Costs for Falls were greater than 50 Billion dollars.
• Medicare and Medicaid paid for 75% of these costs.
• Average hospital cost for a fall injury per incident is 30,000 dollars.
• The cost of treating falls injuries goes up with age.
Fall Prevention is a top focus and quality measure for Medicare due to:

- The frequency of falls in the older population
- The severity of injuries and even death that can result
- The significant cost to the healthcare system
- Improvement in the quality of life for residents
IMPLEMENTING A FALLS PROGRAM

• Helps to reduce cost to the healthcare system
• Decreases re-admissions to hospitals
• Helps to maintain functional status and safety level of the resident
• Improves overall quality of life for the resident
CMS Quality Measure: Falls

Percentage of Falls in your facility with long term and short term residents with or without injury

• This can be an indicator of quality of care in your facility so it’s important to reduce all possible risks.
Risk Factors for Falls

- Previous Fallers
- People with co-morbidities
- Cognitive Issues
- Behavior Issues
- Vitamin Deficiencies (Vit. D)
- Balance Deficits
- Multiple Drug Regimen
- Lower Body Weakness
Risk Factors for Falls (continued)

• Pain/Foot Pain
• Gait Abnormalities (i.e., step length, velocity, BOS)
• Psychosocial Issues (i.e., Depression)
• Nutritional Deficits
• Visual Deficits
• Acute Illness (i.e., UTI)
• Poor Footwear
• Home Hazards (rugs and stairs)
Risk Factors for Falls (continued)

- Decreased sensation (i.e., DM)
- Incontinence
- Arthritis
- Female
- Dizziness
- Orthostasis (i.e., hypotension)
- Functional Limits
- > than 80 years old
Risk Factors with Strongest Association with Falling

- History of Falls
- Gait Problems
- Use of Walking Aide
- Vertigo
- Parkinson’s Disease
- Anti-epileptic Drug Use
- Postural Hypotension
- Poor Sleeping Patterns

More Risk Factors = More Risk for Falls
Dementia Specific Risk Factors

Persons with dementia are two to three times more likely to fall compared to persons without dementia (Kropelin TF, et al.)

• Changes in Insight – judgment and reasoning
• Recognition of sensory input – sight, touch, and sound
• Decreased communication
• Decreased coordination of movement
Dementia Specific Risk Factors (continued)

• Disrupted ability to interpret environment
  • Illusions and misperceptions e.g., depth, light intensity, color, pattern and temperature

• Memory loss

• Poor learning potential

• Inability to initiate tasks – leads to immobility
Other Risk Factors

• If a person fell in the hospital and is admitted to SNF: Danger zone is **first 2 weeks** in the skilled nursing facility after admission.

• Almost 70% of those patients, will fall again, and 5% will die from the fall.
  
  • Mostly attributed to acute illness, environmental change and adverse drug reactions
Risk Factors

- 78% more likely to fall if a person has 4 or more risk factors.
- Underlines need to identify risks upon admission
Proven Prevention to Reduce Fall Risk

• Vitamin D supplement- 800 IU a day or more helps to reduce falls in LTC15

• Exercise
  • should have **strengthening exercises combined with balance exercises with controlled movement** for greatest effect on reducing falls *(ex., Tai Chi, Otago Exercise Program)*
  • walking alone does not reduce risk of falls
Proven Prevention to Reduce Fall Risk (continued)

Visual Assessment and Management

• Be aware that a resident can have an increase in fall risk when change in eyewear occurs.

• OT may need to be involved for a transition period for compensatory/safety techniques.

Withdrawal from Psychotropic Medication17,18

• physician oversight and managed
Proven Prevention to Reduce Fall Risk (continued)

Pacemakers

- Underlying cardiac problems that lead to dizziness, blackouts, and confusion can be reduced by inserting a pacemaker.
- Reduced falls by 2 out of 3 persons

Multifocal lenses

- Increase fall risk in community but not familiar territory
Home/Environment Safety

• Therapy can look at environment and homes for safety issues and make recommendations.
• Therapy can assess footwear and gait deviations.
Treatment of the dementia patient with falls requires an interdisciplinary approach.

- Treatment interventions should target identified needs to optimize the entire care team's health and reduce everyone's health risks. People impacted by dementia—both patients and caregivers—have changing needs for licensed/skilled and unlicensed/unskilled services over time. Their needs may span 5 health domains—behavioral, cognitive, mental, physical, and functional—so care managers should consider all 5, per the results of an international consensus study. McCarthy 2018
People on the dementia spectrum who refuse to move (behavioral domain) and have non-amnesic (non-Alzheimer's) dementia (cognitive), fear of falling (mental), postural collapse (physical), and difficulty walking (functional), may require different care management interventions than do people who are chronic walkers/rockers (behavioral) with amnesic-type (Alzheimer's) dementia (cognitive), depression (mental), pain (physical) and difficulty walking (functional).

Mc Carthy, 2018
Abilities Most Preserved in Dementia

Functions last to decline in persons with Dementia:

- Residual Praxis and Knowledge
- Music and Art
- Humor and Intelligence
- Honesty and Innocence
- Physical Strength
- Resourceful
- Recall of Traumatic or important events
The Importance of Staging

- Dementia affects many areas of function at different rates.
- Staging the dementia determines the current function and how to develop a plan to best care for the affected person.
- Typically, once staged, the person will move to more advanced stages as time passes.
- Treatment strategies can facilitate longer holding patterns from one stage to the next.
The Importance of Staging (continued)

• Provides basis for caregiver education, strategies, approaches in developing patient-centered plan of care

• Helps staff/family provide quality care while focusing on preserved abilities, not limitations
Methods of Staging

Accepted Scales

- NCCDP – 3 stages
- Global Deterioration Scale – 7 stages
- Allen Cognitive Levels – 6 levels:
  - 3 Components:
    - Attention
    - Motor Control
    - Verbal Performance
Mid Stage Characteristics

Profile of mental capability of 12 to 13-year-old

- Can learn with repetition, residual abilities decrease (2-week window)
- Routine is substitute for memory
- 24 hr supervision, home care
- Set up for tasks
- Task completion issues
- Family notices change, need education
Mid– Late Strategies

Remedial Strategies (Failure Free)

• Brain games
• Practice makes Praxis
• Physical cues
• Behavior modification
• Sensory stimulation
• Multi-sensory environments
• Caregiver education
• Participation in Independent/Group/ 1:1 activities
Late Stage Characteristics

- Mental capability of 3 to 5-year-old
- Behaviors increase
- Combativeness/Agitation
- Elopement/Wandering
- Sun-downing
- Falls – more difficulty walking
- Perseveration
- Need total assist for tasks
- Yelling
- Nutritional/ Hydration difficulties
  *(swallowing , feeding)*
Late Stage Strategies (continued)

- Behaviors occur due to unmet need and lack of ability to communicate it
  - Assess Behavior: Figure out what root cause is and plan what can improve it
- Music Sessions - Music and Memory
- Supervised/Assisted activities
- Do not limit walking
- Eliminate stressors that may make them wander:
  - cold temperature
  - change in routine
  - extra noise/chaos
  - incontinence
Late Stage Strategies (Continued)

- Wheelchair wandering if physically unsafe to walk
- Involve with low level activities
- Hoarding - let them collect things as long as safe, fill container, give dollar if needed, give alternative activities
- Continue use of Memory Book (Montessori Techniques)
Late Stage Strategies (Continued)

• **Wandering**
  • May have had a pre-morbid job that involved walking (ex. Postman)
  • Aimless wandering may be due to extra energy- take outside or give physical exercises
  • Modify environment for safety on wander trail
  • Enhance trail with visual/tactile stimulating items
  • Disguise exits with wall mural, black rug, gridlines, guiding words, curtain
Late Stage Strategies (Continued)

- **Elopement**
  - Wander guard
  - Verbal alarm system
  - Mobile locator
  - Know wander pattern and keep watch if does not follow trend
  - What is your elopement plan?

- **Yelling**
  - Studies have shown that giving an appropriate dosage of Acetaminophen has helped constant yelling due to relief of pain; pain is overlooked as a catalyst for yelling
  - Music therapy- can use headphones
Late Stage Strategies (continued)

• **Agitation**
  • Sleep deprivation - keep on diurnal rhythm; keep them busy during day
    • try not to let them sleep, wake up same time everyday no matter what and try to get outside to know difference between day and night
  • Assess for Depression and root cause of agitation
  • Music and cognitive games
  • Cooking
  • Pet visits
  • Snacks
  • Physical activity
  • Visual stimulation
Late Stage Strategies (Continued)

Falls increase

- Good activity plan - keep involved and busy
- Close supervision
- Use of hip protectors
- De-clutter space
- Regular exercise
Why have a Falls Team?

Medicare has recognized **falls as being one of the mostly costly issues for healthcare services** and overall detrimental to the health of the residents in LTC.
Comprehensive Program -
What is it?

Comprehensive Program Definition:
An all-inclusive program covering a broad scope involving people with extensive understanding to provide protection against most risks.
Comprehensive Falls Program

If you attack a Falls program from a comprehensive standpoint, you will keep residents at their most independent level and enhance their quality of life while improving your QM scores.
Falls Program Team Members

- Nursing
- Physician, NP, PA
- Therapy
- MDS
- SW
- Administrator
- Restorative
- Aides

*not all inclusive
Falls Program Structure

1. Initial assessments of all new admits quarterly assessments of all long term residents.

2. Measurement of Previous Status to Current with Risk Factor(s) determined.

3. Placement on Target List for Morning Meeting to communicate to IDT.

4. Review Plans and modify if needed by IDT at Weekly UR or Resident Review.
Assessment of Fall Risk

Should include:

• Both patient specific and general facility review
• History of Falls: circumstance of Fall(s)
• Risk Factors Present
• Medication Review
• Functional Status: Therapy should be involved
• Environmental Assessment
The First 48 Hours
Risks in the First 48 Hours

- Increased disorientation/confusion
- Falls
- PRN use of antipsychotics
- Physical aggression and other behaviors
- Elopement
- Re-hospitalization
- Poor dietary intake
- Increased pain
The First 48 Hours Considerations

Room Placement

- Too near the nurses’ station – loud, disruptive
- Too far from the nurses’ station – no supervision
- Consider 1:1 from family, nursing, activities in a quiet room without roommate noise
- Can use that time for individualized assessments
- Comprehensive Medication Review
- Baseline and Routine Vital Signs/Tracking
Initial Risk Assessment

RESIDENT SNAPSHOT
Prior Level of Function Assessment/Health Profile

Resident Name

Prior to this recent health decline…

Did you help the patient with eating? Yes No
If so, how?

Did the patient have difficulty swallowing? Yes No
How would you describe the patient’s appetite?

Did the patient have a special diet prescribed by physician? Yes No

Did you help the patient with dressing? Yes No
If so, how?

Did the patient have any circulation or skin related problems? Yes No

Did you help the patient with walking/getting up going up stairs? Yes No
If so, how?

Any history of falls? How often and under what circumstance?

Did you help the patient with bathing/bathroom use? Yes No
If so, how?

Was the patient continent of bowel and bladder?

Was the patient able to make good decisions/had reliable memory? Yes No

Did the patient have behavioral/psychological/elonement issues? Yes No
Pre-Admission Survey

FAMILY/CAREGIVER/PATIENT CENTERED CARE ADMISSION INTERVIEW

Date:

Patient Name:

Referring to be called:

Interviewer:

Interviewed:

Activities of daily living: bathing/dressing/personal hygiene

What activities of daily living does your family member complete on his/her own?

- Bathing
- Dressing
- Personal Hygiene
- Self-feeding
- Other

Does your family member prefer:

- Shower
- Bath

If those activities require some assistance, what ways have you found that help accomplish those tasks with ease?

Are there certain approaches, time periods or environments that cause more frustration during these tasks?

What are your family member's favorite foods?

Does he/she have any dietary restrictions (medical or patient implemented)?

What is his/her typical appetite per meal?

Does your family member routinely wear:

- Dentures
- Glasses
- Hearing Aides

Date of last exam: ___________________________ Date of last exam: ___________________________

Daily Routine: Typical daily schedule

Can you describe your family member's daily routine including sleeping patterns (rising time, naps, bedtime), meal, activities they've enjoyed?

Does he/she exercise (walk the dog, walk in the park, yoga, work out, etc.)?

- Yes
- No

If yes, what?

How often?

Does he/she enjoy visitors or other breaks from the normal routine?

How well does he/she adapt to interruptions of that normal routine?

Can you describe any instances where your loved one expressed increased frustration with the above?

Were there certain calming interventions (music, tone of voice, change in environment) that typically worked?

Mobility/Activities of interest

What other activities does he/she still enjoy doing?

- Watching TV
- Reading
- Listening to music
- Crafts
- Pets
- Looking at family pictures
- Other

Does any of these increase or decrease his/her frustration?

Behavior Patterns

Any consistent behavioral patterns?

- Wandering
- Ceiling out
- Striking out
- Other

Has family member displayed symptoms or been diagnosed with Depression?

- Yes
- No

If yes, what?

Were you able to determine what might cause these behaviors?

- Yes
- No

If yes, what?

Were there specific interventions that used that were successful in helping to solve the pattern of behavior?

Interviewer Signature: ___________________________ Patient Name: ___________________________

Date: ___________________________
Algorithm for Fall Risk Assessment & Interventions

- Waiting room: Patient completes Stay Independent brochure
  - Identify main fall risk factors

- Clinical visit: Identify patients at risk
  - Fall in past year
  -Feels unsteady when standing or walking
  -Worries about falling
  -Scored >24 on Stay Independent brochure

- Evaluate gait, strength & balance
  - Timed Up and Go
  - 30-Second Chair Stand
  - 4 Stage Balance Test

- Gait, strength or balance problem
  - ≥2 falls or a fall injury
  - 1 fall in past year

- Determine circumstances of latest fall

- Conduct multifactorial risk assessment
  - Review Stay Independent brochure
  - Falls history
  - Physical exam
  - Postural dizziness/postural hypotension
  - Cognitive screening
  - Medication review
  - Feet & footwear
  - Use of mobility aids
  - Visual acuity check

- Implement key fall interventions
  - Educate patient
  - Enhance strength & balance
  - Improve functional mobility
  - Manage & monitor hypotension
  - Manage medications
  - Address foot problems
  - Vitamin D +/- calcium
  - Optimize vision
  - Optimize home safety

- Patient follow-up
  - Review patient education
  - Assess & encourage adherence with recommendations
  - Discuss & address barriers to adherence

- No to all
  - No gait, strength or balance problems

- No falls in past year
  - Education patient
  - Refer to community exercise, balance, fitness or fall prevention program

Fall Risk Evaluation

Complete evaluation upon admission, quarterly or with a change in status.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Score</th>
<th>Resident Status/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Age</td>
<td>1</td>
<td>&gt;80 years old</td>
</tr>
<tr>
<td>B Mental Status</td>
<td>0</td>
<td>Alert &amp; oriented x 3 or comatose</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Disoriented x 3 at all times</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Intermittent confusion</td>
</tr>
<tr>
<td>C Ambulation/ Elimination Status</td>
<td>0</td>
<td>Ambulatory &amp; continent</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Elimination with assistance</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Independent &amp; continent</td>
</tr>
<tr>
<td>D History of falls past 3 months</td>
<td>0</td>
<td>No falls</td>
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<tr>
<td></td>
<td>2</td>
<td>1-2 falls</td>
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<tr>
<td></td>
<td>4</td>
<td>3 or more</td>
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<tr>
<td>E Vision</td>
<td>0</td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Some impairment</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Legally blind</td>
</tr>
<tr>
<td>F Blood Pressure</td>
<td>0</td>
<td>No noted drop between lying and standing</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>SBP drops &lt;20 mm HG between lying and standing</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>SBP drops &gt;20 mm HG between lying and standing</td>
</tr>
<tr>
<td>G Gait and Balance</td>
<td>0</td>
<td>Steady gait/balance</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Balance problem while standing/walking</td>
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<td></td>
<td>1</td>
<td>Decreased muscle coordination</td>
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<tr>
<td></td>
<td>1</td>
<td>Gait pattern changes through doorway</td>
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<tr>
<td></td>
<td>1</td>
<td>Unstable when making turns</td>
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<tr>
<td></td>
<td></td>
<td>Requires assistive device (cane, walker, w/c, crutch etc.)</td>
</tr>
</tbody>
</table>

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50
Long Term Residents

- Quarterly assessment using Fall Assessment and Screening systems through Therapy
- Incident Report Form
- Weekly Screening through Clinical Review Rounds or IDT meetings
Utilization/Resident Review

• This should consist of a weekly comprehensive review of all risk factors not just for falls.
• Proper referrals to address needs are determined by the IDT and assignment sheets are completed.
Clinical Review Rounds

- Weekly review of upcoming assessments for the long term care residents.
- Can involve therapy, restorative, nursing and aides during screening process.
- Chart review and Observation completed
- Point of service documentation and proper referrals
Weekly Meeting - UR

**Resident Review**

This form will be filled out weekly by the MDS Coordinator and Therapy and distributed to IDT at least 1 day prior to “Resident Review/Part B Meeting.”

<table>
<thead>
<tr>
<th>Facility</th>
<th>Resident Review (2-3 weeks prior to ARD)</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Part B Screens</th>
<th>Most Recent RUG and ADL</th>
<th>CMI (Weight)</th>
<th>Most Recent Therapy Date/Service</th>
<th>Quality Measures CASPER/QIs</th>
<th>Recommendations Therapy and discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
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<td>PT OT ST</td>
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</tbody>
</table>

All IDT members are to bring any and all pertinent information to the meeting. Please be prepared to discuss.

**Restorative**
- Any restorative programs and if there has been a decline

**MDS**
- Communication
- Vision

**Nurse Aide Supervisor**
- Hands on care
- Transfer of care
- Other
Issue Found

• May find decline or issue during screening process OR incident occurs
• Utilize tools to document
  • Pause: What is the root cause?
  • Fall Incident report
  • Medical Necessity Form
5 WHYs TOOL

Problem Statement: (One sentence description of event)

WHY?

WHY?

WHY?

WHY?

WHY?

ROOT CAUSE(S)

1.

2.

3.

To validate Root Causes-Ask the following:
If you removed this Root Cause, would this event have been prevented?
Pause: What is the Root Cause?
Fall Investigation Tool

All information below reflects what happened at the time of the incident.

Resident Name: ___________________________ Date: ___________________________ Time of Incident: ___________________________

Location of fall: ___________________________ Activity prior to fall: ___________________________

Brief description of fall: ___________________________

What does the resident state happened?

__________________________________________________________________________

What do other witnesses state happened?

__________________________________________________________________________

ROM: [ ] WNL or [ ] Not WNL

Pain: [ ] Yes [ ] No Location/Description of injury: ___________________________

[ ] Mild (pain expressed but does not interfere with activity) [ ] Moderate (pain interferes with normal activity) [ ] Severe (pain excruciating)

T _______ P _______ R _______ BP at [ ] sit or [ ] lay ________ BP at [ ] sit or [ ] stand ________

PERRLA (If applicable, explain concerns)

Environmental Concerns: (room order, glare, wet floor, equipment failure, etc)

Contributing Factors: [ ] Positioning [ ] Behavior [ ] Cognition [ ] Acute Illness [ ] Gait Disturbance [ ] Unmet Need

[ ] Vision Impairment [ ] Other Explain all checked:

Was resident continent at time of fall? Bowel: [ ] Yes [ ] No Bladder: [ ] Yes [ ] No Time last toileted: ___________________________

[ ] Use of Alarm [ ] Use of Restraint Explain alarm or restraint use
## Medical Necessity Form

### Functional Decline/Medical Necessity Report: Nursing Note

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>has had a functional decline in the following areas.</th>
</tr>
</thead>
</table>

- Decline not temporary (i.e., not caused by UTI, flu, etc.)
- Decline not caused by side effect of medication

### PHYSICAL THERAPY (check all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Now assist; prior assist.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair mobility</td>
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<tr>
<td>Transfers</td>
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<tr>
<td>Ambulation</td>
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<td>Bed Mobility</td>
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</tbody>
</table>

or

New issues with:

- Lower body contracture
- Unhealing wounds
- Falls
- Pain that affects
- Unsteady balance affecting functional mobility
- Other

### OCCUPATIONAL THERAPY (check all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Now assist; prior assist.</th>
</tr>
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<tbody>
<tr>
<td>Upper body ADLs</td>
<td></td>
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<tr>
<td>Lower body ADLs</td>
<td></td>
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<tr>
<td>Toileting</td>
<td></td>
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<td>Personal Hygiene</td>
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<td>Self-feeding</td>
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<tr>
<td>Bathing</td>
<td></td>
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</tbody>
</table>
What Next?

If your new admit triggers as a Falls risk OR you identify issue with long term care resident: then you should have a target list or “war board” to discuss this resident as part of stand up meeting or risk meeting on a daily basis.
Target List

**H.A.L.T.T. Target List**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date Identified</th>
<th>Issue</th>
<th>Comments</th>
<th>Resolved</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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# Assignment Sheet

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<th>Date to Be Completed</th>
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Daily/Weekly Monitoring

- Each resident will continue to be monitored and reported on in morning meeting on their progress and status of plan.
- Assignment sheets will be reviewed in weekly meeting and modifications may be made by IDT
Communication and Training

- Document all information during Falls meetings and interventions
- Can use log but should have nursing note or IDT note 1x a week for everyone and everything discussed in meeting.
Communication and Training

• Once end result is achieved, communicate to all care staff and make sure all training is complete.
• Use sign off sheets during training with dates completed, who attended and who instructed.
Communication and Training

• Update Falls Log that plan was put into place, all care staff trained and resident successful with adaptations. Nursing will follow for next 2 weeks for carry over.

• Nursing should write note on carry over and positive impact to function and quality of life for resident. Report at UR meeting with ongoing status of patient.
Nursing Log and Note

Functional Decline/Medical Necessity Report: Nursing Note

Patient Name ___________ has had a functional decline in the following areas.

☐ Decline not temporary (i.e., not caused by UTI, flu, etc.)
☐ Decline not caused by side effect of medication

PHYSICAL THERAPY (check all that apply)

☐ Wheelchair mobility
   Now ___________ assist; prior ___________ assist.

☐ Transfers
   Now ___________ assist; prior ___________ assist.

☐ Ambulation
   Now ___________ assist; prior ___________ assist.

☐ Bed Mobility
   Now ___________ assist; prior ___________ assist.

or

New issues with:

☐ Lower body contracture

☐ Unhealing wounds

☐ Falls

☐ Pain that affects ________________

☐ Unsteady balance affecting functional mobility

☐ Other

OCCUPATIONAL THERAPY (check all that apply)

☐ Upper body ADLs
   Now ___________ assist; prior ___________ assist.

☐ Lower body ADLs
   Now ___________ assist; prior ___________ assist.

☐ Toileting
   Now ___________ assist; prior ___________ assist.

☐ Personal Hygiene
   Now ___________ assist; prior ___________ assist.

☐ Self-feeding
   Now ___________ assist; prior ___________ assist.

☐ Bathing
   Now ___________ assist; prior ___________ assist.
Communication and Training

- Team will recommend discharge from At Risk List
- Written status/adaptation should be present in a private place so care staff can access it easily during care.
- Resident will be reviewed quarterly
Staff Education

• Includes whole house education and culture change
• Accountability to everyone to make it successful
• Staff competency checklist and procedures need to be in place
• Education needs to be consistent and often
### Staff Competency Checklist

**STAFF COMPETENCY: DEMENTIA/ALZHEIMER’S CARE**

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<th>Name:</th>
<th>Satisfied</th>
<th>Needs Additional Training</th>
<th>Comments</th>
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- Gait belt use
- Approach to treatment
  - introduce
  - approach from front
  - eye contact
  - touch
  - tone of voice
- Understand indicators for pain
  - facial expressions
  - verbal expressions
  - behavioral expressions
  - physical/functional changes
- Understands need for engagement
- Understands importance of nutrition/hydration monitoring
- Understands dignity for patient
  - no yelling
  - no arguing
    - validation of patient
- Understands importance of communication to nursing of any change in condition of resident
- Aware of importance of daily ADLs
  - task segmentation
  - patient preferences
  - environment awareness
- Understands importance of patient preferences
- Understands tools or approaches for patient’s wants and needs
- Understands need to keep patient/others safe
- Aware of language references for patients with Dementia/Alzheimer’s
- Aware of sleep patterns and bowel and bladder routine
- Aware of impact to patient with regard to changes to routine or environment
- Able to locate patient specific information and use it effectively
- Communicate with dementia residents using focused approach.

**Trainer Signature:** ______________________  **Date:** __________

**PREMIER THERAPY**
Discharge

- Review of Discharge checklist by the IDT will be completed prior to discharge.
- All training of care staff and families must be done prior to discharge from program.
- Update given at morning meeting and resident is removed from target list.
Discharge Checklist

Discharging a Patient

If the most recently established goals have not been met

If you are discharging this patient because progress is no longer being achieved ask yourself the following questions:

- What is the reason for this patient having plateaued?
- Has the therapy been comprehensive in meeting all of the identified deficit areas?
- Does this patient have cognitive deficits that prevent making the expected progress in therapy?
- If yes, how can I adjust the treatment strategies?
- Have all of this patient’s goals been met?
- Do new goals need to be established?
- Has the therapy been frequent enough?
- Has the therapy been as intense as needed?
- Have I used the optimal treatment approaches?
- Do I have the necessary equipment?

Discharge Planning Checklist

Patient Name: ____________________________

Anticipated Discharge Setting: ____________________________

Assist with Care Available: ____________________________

Patient will be handling own medication regimen.
  □ Yes  □ No
  If yes, patient has demonstrated ability to do so with competence.
  □ Yes  □ No

What medical equipment will be required at discharge?

__________________________

□ Patient/caregiver has been trained to use appropriately.

Patient/caregiver has demonstrated good ability to complete or assist with:

□ Up and down stairs
Case Scenario

80 year old female admitted with exacerbation of COPD. Currently Min assist with ambulation

• Past Medical History: Lewy Body Dementia, DM, atrial fib, and Right hip fracture 2 years ago
Case Scenario (continued)

- Prior to hospital stay the resident ambulating without a device, throughout the unit. Alert and oriented to self only, no behaviors
- She has a documented fall about 1 week before going into the hospital – pt found in hallway, no injuries
- She has numbness in her feet from DM
Case Scenario (continued)

• New Admit: Nursing/MDS complete PLOF, Fall Risk and What’s Your Risk assessments.
• Resident triggered as a high risk for falls on the assessments due to decreased functional ability, significant decline from PLOF, uncontrolled DM and fall history
• Nursing places resident on target list as “at risk.”
• Resident is discussed with IDT in next morning meeting as having issues and all therapies are ordered to complete evaluations.
## Target List

### H.A.L.T.T. Target List

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<th>Patient Name</th>
<th>Date Identified</th>
<th>Issue</th>
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Case Scenario (continued)

• Resident is discussed in morning meeting and update given as preliminary plan.
• Resident discussed in Weekly UR\Resident Review meeting by entire IDT
• Utilize Tool for Root Cause
• Care Plan with Family to know D/C goals
Root Cause Tool
Case Scenario (continued)

- Assignment sheets are completed by Nursing in UR with Issues identified, persons responsible and date of completion.
- Document on Log brief explanation of IDT decisions and refer to assignment sheets.
- See Example
Assignment Sheet

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RE: Resident ___________________________  To be turned in to: ___________________________
Progress and Review

• Update team each morning on plans
• Review Assignment sheets at Weekly UR meeting- Hold staff accountable
• Write in actions taken for the previous week and if completed or ongoing
• Add new assignments if needed
Discharge

• IDT can recommend removal from target list when all parts of plan completed
• Review discharge checklist in UR with IDT to make sure all is done
• IDT will recommend in next morning meeting to remove resident from “at risk” target list
Discharge Checklist

DISCHARGING A PATIENT

IF THE MOST RECENTLY ESTABLISHED GOALS HAVE NOT BEEN MET

If you are discharging this patient because progress is no longer being achieved ask yourself the following questions:

- What is the reason for this patient having plateaued?
- Has the therapy been comprehensive in meeting all of the identified deficit areas?
- Does this patient have cognitive deficits that prevent making the expected progress in therapy?
- If yes, how can I adjust the treatment so realistic goals can be achieved?
- Have all of this patient’s goals been met?
- Do new goals need to be established?
- Has the therapy been frequent enough?
- Has the therapy been as intense as needed?
- Have I used the optimal treatment approach?
- Do I have the necessary equipment/material to thoroughly treat this patient?
Quarterly Review

This person, unless discharged to another environment, would be reviewed quarterly upon clinical rounds/screens to make sure plan still appropriate or if a comprehensive assessment is needed again.
Treatment Inventions by Therapy to help reduce falls

- Comprehensive Evaluations by OT, PT, and ST as appropriate
- Recommendations to other IDT members as needed such as psychiatrist, dietary, respiratory therapist, wound nurse etc.
Possible PT/OT Interventions

• Progressive Strengthening Program
• Pain Management Program through Stretching, Modalities, Positioning and Adaptive Equipment
• Wound Care Program
• Static and Dynamic Balance Program
Possible PT/OT Interventions

- ADL Re-training
- Environmental Modifications
- Home Safety Assessments
- Prosthetic and Orthotic Assessments/Fittings/Training
- Behavior Modifications (CALMM)
- Low Vision Techniques and Adaptations
Possible ST Interventions

- Cognitive Assessment
- Consulting with Dietary on Nutrition and Intake
- Techniques to Reduce Behaviors
- Dementia Programming (CALMM)
- Environmental Stimulation
Thank You!
Questions?

Please feel free to contact: Heather Meadows at: hmeadows@embracepremier.com

2. Tools to Implement the Otago Exercise Program: A Program to Reduce Falls 1st Edition, CDC. Accessed October 2018


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5. Comprehensive Accreditation Manual for Long Term Care Refreshed Core, January 2011


7. Internet: http://www.primaris.org/sites/default/files/resources Accessed April 3, 2018

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