Success Story #1

Resident was becoming a high fall risk soon after admission. Staff brought pink incident sheets to morning stand up meeting to review amount of falls and times of incidents. Found that there was a pattern being repeated, the falls were happening between 8pm and 4am.

Intervention #1

The first idea was to not take him back to his room immediately after supper, but to be assisted to the memory loss unit for programming until 9pm.

Problems with this intervention were that his behavior increased at various times while on the unit or that he was not always engaged in the group. Team thought that due to inconsistent times of agitation on unit to only try to bring him there 3 or 4 more days because the agitation is affecting others who live on unit. Staff needed to intiate the escort on and off the unit. Therapeutic Recreation staff continued to attempt to engage him in musical groups, simple games and small socials.

On day 4 of the trial resident became extremely agitated, screaming and kicking the door to get out.

Intervention #2

Next we attempted to bring him to the park area to read the newspaper or watch the birds or to sit by nurses station and would not be put in bed until 9pm to keep him up longer and would be ready for bed when everyone else was in bed.

The problem was that staff was not consistent with the intervention. It was added to care cards and night staff had an in service on this intervention. Staff reported they felt bad and wanted to honor the resident's right to be in his room if he asked.

Intervention #3 Team asked if resident could be put on sleep log and to have medications looked at by Doctor.

Intervention#4

Part of the falling leaves program was to put a red leaf up on door frame, and for staff to learn interventions associated with this program. There was an all staff in-service for them to learn about

these interventions, certain ones had been put on care cards and in care plan.

Intervention #5

We put up a mesh stop sign across door way when resident is out of his room to stop him from entering room and being alone. The problem was that falls were still happening from 12am to 4am. Resident had stated he needed to use the bathroom

Intervention #6

From the last intervention we asked if he could have bladder scans and be cathed after his first attempt to get out of bed. If he had a second attempt to get out of bed the staff would need to get the resident up and put him in a public space to monitor safety. An in service on this was done for overnight staff.

Problem believed to be by staff is that he is lonely and the staff take him with them while doing rounds. But this puts staff behind on their rounds. Also resident continues to request to watch TV in his room but cannot be left alone in room.

Intervention#7

Staff asked to put resident in Veterans Lounge to watch TV instead of in his room. Problem here is that it is not a close enough area for visual observation.

Intervention #8

Staff requested to put a TV in the Newsroom with recliners because of better observation of resident in a highly traveled area. This was successful for the overnight shift and has shown a decline in the amount of falls on nights.

Now resident has had new falls while in his room during day because staff was allowing him to watch TV in room because he wants to watch cable shows and Newsroom does not have cable. So staff member will monitor use of TV in Newsroom and if it is used for this resident and also others we will pursue cable hookup. New problem with resident is that he attempts to self transfer to bed during the day.

9th Intervention

Bed will now get put in the highest position to discourage resident from attempting to get in bed. Resident's falls decreased from one month to next by 14. So far in this month of June no falls!

Success Story #2

Resident was at risk of falling due to cognitive status, and was continually setting off tabs alarm, with attempts to self transfer, reach for things on the floor such as tissues she dropped, or wanting to stand up and walk.

We looked at the specific times of the day this was happening with the most frequent attempts was between 2 and 4pm, along with reasons, being usually for the bathroom.

Intervention #1

Staff gave her extension reacher to get things off the floor instead of having to bend over. They showed her how to use it and consistently reminded her as they witnessed her reaching.

Intervention #2

Nursing staff are to offer to assist to the bathroom, if not needed they are to offer to walk with her when she gets up or sets off tabs alarm.

Problem was that not all staff were offering to walk her.

It then was put on care cards and in care plan while also verbally communicated to staff during observation that she was to be offered to walk 2 times a shift.

Success! There has been no falls with this resident due to attempts to self transfer.

Success Story #3

Our pilot project was the beginning of our falls prevention program. After gathering information, it was discovered that there were 6 residents, all at a high risk of falling or have a history of falling. The times identified are between 3 and 4pm with the location being on the memory loss unit and that the falls of these residents occurred in rooms due to reasons such as wanting to get up from chair or get out of bed.

Intervention #1

We made a list of these residents, communicated to nursing staff that were in this small group, and looked at their leisure interest.

We interviewed the therapeutic recreation to determine what supplies may be needed to conduct the table group activities and discussed what activities can be done at a table.

The initial problem encountered was some staff was still not getting people up and along with being unaware of the reasons behind the table group.

Intervention#2

We educated staff of the falls prevention program and answered any questions or expressed concerns they may have. We asked for their input as to where the resident list should be to be easily visible for nursing staff to see.

Problem: Staff had a difficult time with one particular resident who expressed the desire to be in her room, but still kept falling.

Intervention #3

Continued education focusing more on staff approach, and encouraging table group involvement rather then offering a choice to participate or not.

Because of the integration of table groups, we showed a 10% decrease in the falls on Rosewood. In efforts to continue falls prevention, we now have tea time for everyone on Rosewood during this high fall time to not only reduce the chances of falling, but provide socialization, nutrition and hydration.