Fall Prevention Program for Care Ventures Compliance: Falls in the Nursing Home

2010

Why is Minnesota the 3 rd worst state in the nation for falls among all ages in the population?

Our sedentary life style.

- We don't move enough. Winter comes and we stay by the fire side and have in door activities.
- This is similar to when a person falls. The first thing they do is stop moving. "If I don't move then I'll be safe."
- When the elderly stop moving they stop doing ADL, activities, taking in proper fluids. This leads to dependency of ADL, isolations, depression, dehydration and incontinence.
- We need to learn the why, how, where, when and more about falls.

ARE YOU A FSI?

You are a Falls Scene Investigator!

- Everyone needs to be a falls scene investigator!
- When someone falls everyone needs to be able to tell what occurred in a fall situation. Everyone needs to know how to handle falls.

This inservice will help you become a Falls Scene Investigator.

By the end of this inservice you will be able to :

Use Root Cause Analysis to investigate a fall

Gather clues/ Data collection

Learn what needs to be documented and how

Learn what are strong and weak interventions for falls

We will start with 2 questions.

- Do you know what the "Dancing Bear" is?
- What is the first thing you do when you come upon a fall?

- You can find the "Dancing Bear" by going to Goggle or BING and type in the words "Awareness Test"

Know the risk factors!

- Depression- a depressed resident falls 5 times as many times as other residents.
- Medications- 9 or more medications greatly increase the risk of falls.

- Cognition problems
- Pain
- Gait and Balance
- Environmental Changes
- Infections
- Vision
- Improper Foot Wear and Clothing
- Incontinence

- The number one reason for falls in nursing home residents according to the Massachusetts Health Institute is:

Sleep Deprivation secondary to noise in their environment.

Let's think about all the noise around us.

- What are some sources?
- Vacuums
- TV and Radios
- Paging Systems
- Walkie Talkies
- Talking
- Food Service
- Activities

- Listen to what a normal AM shift change sounds like to a sleeping resident. No wonder they are sleep deprived.

Did you know the cost of a fall?

- Pain and injury to the resident.
- Clinical care following a fall= $10,000-$12,500.
- Diagnostic testing
- Decline in resident ADLs, cognitive skills and mood.
- VA investigations
- Poor family and public relations and reputations
- More equipment needs
- Education and training
- Legal expenses
- And more....

So now that your awareness has been raised about falls we will become FSI.

- To be a FSI you need to pretend that a fall is like a crime scene that needs to be solved.
- Step One > Step Two > Step Three
- 1) gather the clues and evidence by observation, examination and collection.
- 2) Investigate and analyze: Why did they fall? Determine the root cause or reason for the fall.
- 3) Implement corrective actions/ interventions to eliminate the root cause of the problem.

Step one: gather clues, evidence, data

- Don't be to hasty to move the fallen resident. Send one person to get the nurse and one person to stay at the scene. The first 3 minutes after a fallen resident is found may be the most critical time for gathering information. After that the scene of the fall get changed by memory loss and changes in the environment. Observation skills are critical. Most investigations are done hours later losing vital information about the fall.

- Gather clues by looking, listening, smelling and touching. Note placement of the resident and surrounding environment. Draw the scene if possible. One picture is worth a thousand words.
- Protect the area around the incident by securing equipment and the room. Observe and record the begins immediately while things are fresh in the mind of the resident and the staff.
- Remember the "Dancing Bear".
- Do a post fall huddle.
- Alarm tracking

10 questions to ask at each fall

1) Are you OK?
2) What were you trying to do?
3) Ask resident what was different this time that caused the fall.
4) How was the resident positioned?
5) What did the surrounding area look like?
6) What was the floor like?
7) What was the footwear like?

8) Was the resident using an assistive device?
9) Was the resident wearing glasses or hearing aide if the use them normal each day?
10) Ho was in the area when the resident fell?

Step 2 : Root Cause Analysis.

- Decide what the root cause of the fall is. Decide what is the cause of the fall by asking why. Why did this resident fall this time? Why is this time different than any other time? Why didn't the resident use the call light?
- Identify causes of falls: Intrinsic, Extrinsic, Systemic

Intrinsic= Internal

- Balance, sleep deprivation, medications (type and amount) B/P, distance fall occurs from transfer surface, pain, continence status(check the toilet contents), cognitive status, mood, depression, vision/ hearing loss, O2 deprivation.

Extrinsic= environmental

- Noise(alarms, shift change, TV), environmental contrast, room/ bed assignment, placement of furniture and personal items, lighting, flooring, footwear/ clothing, mats- the noisier the facility the more falls occur

Systemic = Operations

- Time of day, shift change/ times, break times, day of the week, location of fall, type of fall, routine assignments(cleaning, stocking, repairing) staffing levels. 99% of the time a fall occurs something is going on in the nursing home.

Environmental Evidence

Place of the fall:

At bed side	5 feet away	>15 feet away
Othrostatic B/P	Balance/gait	strength/ endurance

When a fall is in the bathroom the Dancing Bear is is in the toilet!
In bathroom /commode = check contents
Urine/ feces/ diarrhea in commode? Did they have a Vagal Maneuver?
Urine on the floor? Before of after the fall?

Pacing vs. Wandering

- Pacing= needs not met-highly repeative and needs to be stopped- meet their needs-looks angry or anxious
- Wandering= without purpose- wanders for comfort/ to find peace - don't interrupt unless enters harmful area or tired

Grabbing vs. Pushing

Grabbing: due to dizziness to stop spinning- holding on

Pushing: to get away from being startled/ attacked- back away

Gathering Clinical Evidence

1) Othrostatic B/P, vitals, consciousness, bleeding, pain, hand grasp, PEARL.
2) Last meds(type), last eaten, last voiding, sleep/ restless, pain history, (the 4 P's
3) Glucose levels, HgB,& Hct(anemic), O2 sats, UA/UC, xrays, med reviews
4) Behaviors- wandering/pacing/pushing / grabbing

Why did this resident fall?

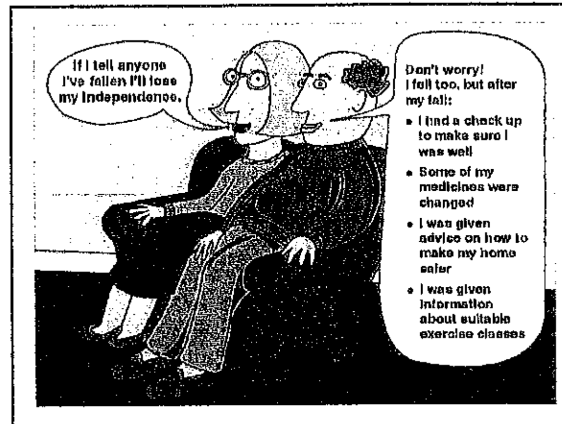
Case Study:

An independent resident has fallen. After the fall a CNA reports she has not been eating and drinking as much as she normal does and she did not change her blouse today. The CNA noticed her in the bathroom more but was in a hurry, so she did not say anything to the nurse. Activities aide reports she has been staying in her room more the last few days and avoiding activities she normally likes. Family said they thought she was a little confused at her last visit. You are the FSI. Why did this resident fall?

FSI REPORT/ Why do you think she fall?

- Was she tangled in the bed spread?
- She was wearing her glasses or hearing aids?.
- Why wasn't she using her walker?
- Why was her sweater ½ on, half off?
- Why did she have on 2 different shoes?
- What was she trying to do at time of the fall?
- Does she have weakness? Does she have an infection?

What happens next for this resident?



Answer to the investigation!

- She fell due to a decline in her condition. This decline was noticed but not reported. The CNA saw she was not eating as usual. The activities aide noted she was not attending activities which is a sign she may not feel well or is depressed. The family thought she was just a little confused. No one added up the signs of depression, infection, pain or condition change.

What can be done?

- She may have a UTI. The doctor can be contacted and a urine test can be done. Antibiotics may help.
- Encourage fluids, meals and rest.
- Assist with ADLs as needed until the infection has past.
- Contact PT/OT for evaluation/ referral for strength, balance and ADLs training.
- Referral for exercise program to maintain strength.

Interventions

- Is a term in which residents receive external treatments or actions that have the effect of preventing injury or prolong life.

Hierarchy of Actions and Interventions

- Weak: actions that depend on staff to remember their training or remember what is policy and procedure. Reminders are the weakest intervention. Posters and signs. Auditing without follow up. Interventions include checklist, increase staffing , decrease work load, assignment sheets.
- Intermittent: actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff remember or to promote clear communication. This is care planning and rounding.
- Strong: actions that do not depend on staff to remember to do the right thing: the action may not totally eliminate the vulnerability but provide very strong controls. Engineering controls that stop exit until assignment is done. (E mar). Audits with follow up. Identifies weakness and strengths forms plans and can measure effectiveness of plan.

Interventions

- Extrinsic:

Noise reduction, D/C alarms, turn down/ off TV or radios, don't page more than needed, whisper at shift change or go the a room and close the door, change furniture and personal belongings, adjust height of bed, change room assignments, walkers, mats, foot wear and clothing, hip protectors and helmets.

Interventions

- Intrinsic:

Offer opportunity to balance, improve sleep deprivation, address othrostatic B/P, reduce medications, PT/OT, referral for distance fall occurs from transfer surface, toileting plans, and programs, eliminate pain, address cognitive issues, mood and depression, corrective eye wear and hearing aide checks, prevent O2 deprivation.

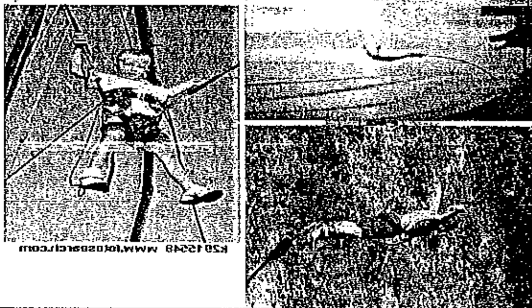
Interventions

- Systemic :

Hourly rounding, staffing and break times adjusted to needs and fall times to the residents, equipment repairs, room and bed assignments changes.

EVERY FALL MUST HAVE AN IMMEDIATE INTERVENTION!

Some times no matter what you do they are going to fall. We still need to try to prevent all falls.



We are all

FSI!!!!!!

Remember....

Gather clues, investigate and implement changes to prevent the next fall.

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Remember to look for "The Dancing Bear!"

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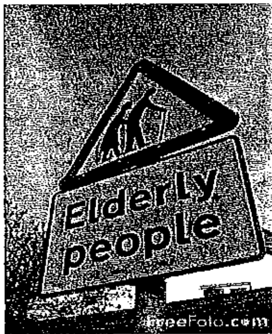

- They depend on us to keep them safe.

RCA: Interventions:/
RCA: slide out of bed/bed resting on baseboard heater. Intervention: /pushed the bed off of the heater.
RCA: slide out of bed/ bed still slant downwards on heater. Intervention:/ mattress/bed guard on & crates on floor so the bed is not next to the heater.
RCA: walker caught on the carpet, pain meds had been increased./ Use w/c and decrease pain meds.
RCA-impulsive behavior with no regard for his own safety and not strong enough to stand independently, anti-roll brakes added to w/c, anxiety meds increased.
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RCA: dizziness; f/u by NP /w med review, signage in room, check shoes/socks, f/u on c/o poor vision in R eye
RCA:agit, DR crowded, & flipd w/c over./Rearranged DR,anti tips put on w/c.
RCA:stood to reach for wash cloth on table he had pushed away./ Rearranged rm per his liking.
RCA:agitd & angry, declining & need to void./ Check w/him q2h for BR needs, f/u psych visit today.
RCA:inc weakness d/t lung CA, w/c unlocked./ Staff to check W/C brakes w/ rounds (Refuses anti-roll brakes)
RCA:became belligerent w/staff swung & lost bal./Needs calm approach, one direct at a time & 2 staff to walk him.
RCA:stumbled over rmmate's WW left by BR door./Staff to do more freq checks both use BR freq.
RCA:wants to be ind., ataxia, lost balance & fell./No new intervention.
RCA:bent over to p/u item dropped./Issued reacher.
RCA:dropped item & bent over to p/u/ none (already given reacher.)
RCA:fatiqued,sundwng,wanted to go to bed./Place in bed by 6:30 pm if tired & get up later if wishes, was a fireman w/erratic sleep.
RCA:stumbled over folded walker lookg for fam, after fam left. /Turn on TV, offer interest items, or bring to common area keep ww open & in reach.
RCA:stumbled, pants around legs./ Staff now to assit w/cares in am.
RCA: walker snagged on carpet./ Replaced sticky tennis balls with plastic caps.
RCA: resident rasied bed ht. too high./ Lock out bed at approiate ht., replace poorly operating bed control.
RCA:Resident was told she would have help getting into bed so she did not put on her call light. After waiting, resident attempted self-transfer and fell when going from wheelchair to bed. INTERV: Remind resident to use call light even if staff say they are coming to help. Remind staff to frequently check on resident and put call lights on to remind them to go back to resident if request can wait.
RCA:Resident slipped out of wheelchair while attempting to boost self back when chair slipped out from underneath her. Gripper sock slipped off at time of fall. INTERV:Resident given new gripper socks and educated/reminded to use brakes when boosting back in chair.

Remember to look for "The Dancing Bear!"