Why are we very concerned about falls?

Falls are a major health risk for our elderly population. One out of every three older Americans falls every year. Only 1/2 of all elderly people can live alone or independently after sustaining injuries from a fall. Falls are a significant source of fractures and soft tissue injury. Falls are the most common cause of severe injury in older adults.

Who is at the highest risk for falling?

Falls are most likely to occur in elderly persons who have:

- ~ Recently fallen
- ~ Difficulty balancing, walking or standing up straight
- ~ Difficulty getting in and out of a chair, car, bed or on and off of a toilet
- ~ Dizziness
- ~ Pain
- ~ Weak bones & muscles
- ~ Multiple medications
- ~ Vision and/or hearing loss
- ~ Memory loss or confusion

Our goal is to provide a safe and healthy environment.

Our staff has been trained to reduce the risk of falling for you and your family member.

We are working to identify the causative factors of falls.

The information contained within this brochure is not intended to replace seeking medical attention.

This educational information is provided to you by Empira in association with your Assisted Living, Independent Living or Skilled Nursing Facility.

Family & Friends:

Fall Prevention

How You Can Help!

I look forward to meeting with you to discuss Fall Safety.

Name _____.

Here's how you can contact me:
Phone _____
E-mail _____

Fall Management Program:

A fall can happen to anyone at anytime. Illness, surgery, weakness, tests, medication, medical equipment, noise and new surroundings can all contribute to a fall at any age.

We need your help!

Would you please help us to manage and hopefully reduce falls?

Here's what you can do:

- **If your loved one fell or has a history of falling prior to admission, let us know.**
- **If your loved falls when out of the facility with you, please tell us.**
- **Learn how to properly transfer and move a resident, we will show you how to do this safely.**
- **Have them wear non-skid, low heeled, fully enclosed shoes.**
- **Instruct and help them to stand up slowly from a lying or sitting position to prevent dizziness.**
- **Encourage them to walk often, using their cane or walker, even inside of an apartment, home or in their room.**
- **Tell us when you are leaving after your visit, so we can make sure safety measures are in place.**
- **Talk with their nurse or doctor if they experience any of these side effects from medications: dizziness, unable to balance, or a change in their ability to walk.**

Here's what we will also do:

1. **We will work with you and your loved one to identify their risks for falling.**
2. **We will conduct a post fall investigation and assessment to identify the possible causes of their fall.**
3. **Physical, Occupational and Recreational Therapies will provide programs and services to help keep them strong, oriented and active.**
4. **We will talk with their doctor and pharmacist to determine if any medications, medical actions, or treatments need to be changed or taken.**
5. **We will take action by putting interventions into place to reduce the likelihood of future falls from occurring.**
6. **We will provide equipment and safety devices to reduce their risks for falling.**

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

Date of Fall _____ Time of Fall: _____ AM / PM Admit Date: _____

Staff / Witness present at / or finding resident after fall: _____

FALL DESCRIPTION DETAILS:

1. Factors observed at time of fall:
   - ☐ Resident lost their balance
   - ☐ Resident slipped (give details):
   - ☐ Lost strength/appeared to get weak
   - ☐ Wheelchair / bed brakes unlocked
   - ☐ Bed height not appropriate
   - ☐ Equipment malfunction (specify):
   - ☐ Environmental noise
   - ☐ Environmental factors (circle or write in): clutter, furniture, item out of reach, lighting, wet floor, other (specify)

2. Draw a picture of area and position in which resident was found. (e.g. face down, on back / R or L side, position of arms and legs, furniture /equipment /devices nearby)

***If fall is within 5 feet of transfer surface do orthostatic BP**

3. Fall Summary:
   - ☐ Found on the floor (unwitnessed)
   - ☐ Fall to the floor (witnessed)
   - ☐ Intercepted fall (resident lowered to floor)
   - ☐ Self-reported fall

4. Fall Location
   - ☐ Resident room
   - ☐ Activity Room
   - ☐ Hallway
   - ☐ Dining room/day room
   - ☐ Bathroom [CHECK TOILET CONTENTS]
     - ☐ Toilet contains urine /feces
   - ☐ Shower/tub room
   - ☐ Outside building on premises / off premises
   - ☐ Other (specify) :

5. What was resident doing during or just prior to fall?
   - ☐ Ambulating
   - ☐ Attempting self-transfer
   - ☐ Transfer assisted by staff
   - ☐ Reaching for something
   - ☐ Slide out / fall from wheelchair
   - ☐ Rolling/sliding out of bed
   - ☐ Sitting on shower/toilet chair
   - ☐ Other (specify):

6. What type of assistance was resident receiving at time of fall?
   - ☐ Assisted per care plan:
   - ☐ Alone and unattended
   - ☐ Assisted with more help than care plan describes

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

7. What did the resident say they were trying to do just before they fell?

CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:

8. Describe resident's mental status prior to fall:

How does this compare to the resident's usual mental status?

9. Describe resident's psychological status prior to fall:

How does this compare to the resident's usual psychological status?

10. Footwear at time of fall:
- ☐ Shoes
- ☐ Bare feet
- ☐ Gripper Socks
- ☐ Slippers
- ☐ Socks
- ☐ Off load boots
- ☐ Amputee

11. Gait Assist devices at time of fall:
- ☐ None
- ☐ Has device and was in use
- ☐ Has device but was not in use

12. Did vision or hearing contribute to fall?
- ☐ Yes
- ☐ No

Explain:

13. Alarm being used at the time of the fall?
- ☐ Yes
- ☐ No

If yes, was it working correctly?

14. Time last toileted or Catheter emptied:
_____ AM /PM

Continence at above time:
- ☐ Wet ☐ Soiled
- ☐ Dry

15. Did fall occur?
- ☐ Next to transfer surface (assess postural hypotension)
- ☐ 10 ' from transfer surface (assess balance)
- ☐ > 15 ' from transfer surface (assess strength /endurance)

16. Medications given in last 8 hours prior to fall (check all that apply):
- ☐ Diuretic
- ☐ Anti-depressants
- ☐ Narcotics
- ☐ Anti-anxiety
- ☐ Anti-psychotics
- ☐ Seizure
- ☐ Cardiovascular
- ☐ New meds/changed dose within last 30 days

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

17. Vital Signs:
- ☐ Were temperature, pulse, respirations and/or O2 Sat out of normal range for this resident?
  - ☐ Yes
  - ☐ No
- ☐ Did orthostatic BPs suggest the BP change contributed to the fall? Lying _____
  - ☐ Yes Sitting _____
  - ☐ No Standing _____

18. (Blood Sugar check is required for diabetic resident) Was resident's Blood Sugar significant?
- ☐ Not applicable
- ☐ Blood sugar within normal range for resident
- ☐ Blood sugar out of normal range (describe):

19. Does recent Hgb show evidence of Anemia?
- ☐ Yes
- ☐ No

Re-Creation of Last 3 Hours Before Fall

Below, the primary Nursing Assistant who observed and /or assisted the resident during the three hours prior to the fall will write a description to re-create the life of the resident before the fall:

PRINT NAME:

Re-enactment of fall (to be done if Root Cause is NOT determined):

Fall Huddle *(What was different THIS time?)*

ROOT CAUSE OF THIS FALL:

Review of Contributing factors (Check all that apply):

- ☐ Vital signs abnormal or significant
- ☐ Amount of assistance in effect
- ☐ Alarm
- ☐ Assistive/protective device
- ☐ Footwear
- ☐ Environmental factors/items out of reach
- ☐ Environmental Noise
- ☐ Medication
- ☐ Medical status/Physical condition/Diagnoses
- ☐ Toileting status
- ☐ Mood or mental status
- ☐ Vision or hearing
- ☐ Last 3 hours "re-creation" issue/s

FSI -- Fall Scene Investigation Report

Facility Name:

Resident Name: _____ Med. Rec. # _____ Room # _____

What appears to be the root cause of the fall?	
Describe initial interventions to prevent future falls:	
☐ Care Plan Updated ☐ Nurse Aide Assignment updated	
NURSE COMPLETING FORM:	
Printed Name: _____ Signature:	Date and Time:
Falls Team Meeting Notes:	
Summary of meeting:	
Conclusion:	
Additional Care Plan / Nurse Aide Assignment Updates:	
Signatures with Date and Time:	

Empira, 2015 Fall Prevention and Elimination; Evidence Based Resources, Reports of Practice, Professional Journal Articles, Public news reports:

Root Cause Analysis:

1. **"Root Cause Analysis,"** VA National Center for Patient Safety, US Department of Veterans Affairs, http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
2. **"The Root Cause Analysis Handbook: A Simplified Approach to Identifying, Correcting, and Reporting Workplace Errors,"** Max Ammerman, October 2015 online in PDF http://www.maxreadersonline.eu/7436rugo.pdf
3. **"Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients."** *Health Affairs*, Giardina, T.D., et al (2013). *32*(8), 1-8.
4. **"A Cross-Sectional Study on the Relationship Between Utilization of Root Cause Analysis and Patient Safety at 139 Department of Veterans Affairs Medical Centers."** *Joint Commission Resources*, Percarpio, K.B., & Watts, B.V. (2013). *39*(1), 35-40.
5. **"Using Root Cause Analysis to Reduce Falls with Injury in the Psychiatric Unit."** *Hospital Psychiatry*, Lee, A., Mills, P.D., & Watts, B.V. (2012). *34*(3), 304-11.
6. **"Using Root Cause Analysis to Reduce Falls with Injury in Community Settings**." *Joint Commission Journal on Quality & Safety*, Lee, A, Mills P.D., and Neily J. (2012). *38*(8), 366-374.
7. **"Using aggregate root cause analysis to reduce falls and related injuries."** *Joint Commission Journal on Quality and Safety*, Mills, P.D., et al (2005). *31*(1), 21-31.
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9. **"The Veterans Affairs Root Cause Analysis System in Action."** *Joint Commission Journal on Quality Improvemen*t, Bagian, J.P., et al. (2002). *28*(10), 531-545.
10. **"Techniques for Root Cause Analysis,"** Baylor University Medical Center, Patricia M.Williams, BS, MT, ASCP. Vol. 14(2): pp. 154-157. April 2001.

Alarm Reduction – Sound, and Noise:

1. **"Nursing Home Alarm Elimination Program: It's Possible to Reduce Falls by Eliminating Resident Alarms."** MASSPRO, Quality Improvement Organization for Massachusetts, Nursing Home Initiative: 2006**.** Website publication: http://www.masspro.org/education.php

2. **"Rethinking the Use of Position Change Alarms."** Quality Partners of Road Island, the Quality Support Center for the Nursing Home Quality Initiative, Positional Paper, Joanne Rader, Barbara Frank, Cathie Brady. January 12, 2007. http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=Dbip2Pr9SdI%3D&tabid=281&mid=2432

3. **"From Institutionalized to Individualized Care. Part 1." The detrimental use of alarms in terms of their effects on residents: 2007 CMS satellite video broadcast training**; http://www.bandfconsultinginc.com/Site/Free_Resources/Entries/2009/7/2_Eliminating_Alarms_~_Reducing_Falls.html

4. **"Effects of a Noise Reduction Program on a Medical-Surgical Unit.,"** Rebecca Taylor-Ford, et al., Clinical Nursing Research, Vol. 17, No. 2, 74-88. May 2008. http://www.sonoma.edu/users/c/catlin/noise%20reduction.pdf

5. **"Management of Falls the Next Step . . . Moving Beyond Alarms and Low Beds."** Molly Morand, BSN, RN, BC, Indiana State Dept. of Health, Indiana Long Term Care Leadership Conference, June 15, 2007. Presentation repeated at the AANAC Convention, Las Vegas, NV. October 2008.

6. CMS, Guidance to Surveyors of Long Term Care Facilities, March 2009, F252 Environment, Interpretive Guidelines, 483.15(h) (1) "Some good practices that serve to decrease the institutional character of the environment include **the elimination of the widespread and long-term use of audible (to the resident) chair and bed alarms**, instead of their limited use for several residents for diagnostic purposes only."

7. **"Wisconsin Success Stories in Restraint and Alarm Reduction,"** Advancing Excellence – Wisconsin Coalition for Person Directed Care. Web conference: June 18, 2009. (archived) http://www.metastar.com/web/Default.aspx?tabid=312

8. **"Staff Solutions for Noise Reduction in the Workplace."** Alison Connor, RN, BSN, The Permanente Journal, Vol. 14, No. 4. Fall 2009. http://xnet.kp.org/permanentejournal/Fall09/StaffSolutionsNoiseReductionWorkplace.pdf

9. MI DHS, Departmental Appeals Board, **Civil Remedies Division**, September 30, 2009, Docket# C-08-690, Decision# CR2011. IDR findings' following falls with alarm use. http://www.hhs.gov/dab/decisions/civildecisions/cr2011.pdf

10. "**The Impact of Alarms on Patient Falls** at a VA Community Center Living." Poster session 2010 Annual Conference: Transforming Fall Management Practices, Department of Veterans Affairs.

11. **"Strategic Approaches to Improving the Care Delivery Process, Falls and Fall Risk."** Dr. Steven Levenson, MN Joint Coalition Statewide Training. May 2010**.**

12. **"What's That Noise? An Account of the Journey to an Alarm Free Culture,"** by Morgan Hinkley, Administrator, Mala Strana Health Care Ctr., Care Providers' Quality First Award, June 2010.

13. **"Eliminating Restraints including Alarms."** Pioneer Network's Annual Convention, Indianapolis, IN. Preconference Intensive. August 9, 2010. Carmen Bowman, MSH & Theresa Laufmann, BSN and DON at Oakview Terrace Nursing Home, Freeman SD.

14. **"Eliminating Restraints and Alarms by Engaging the Whole Person."** Action Pact Culture Change Now Teleconference, August 20, 2010, Carmen Bowman, MSH, Theresa Laufmann, BSN.

15. **"Evidence-Based Design Meets Evidence-Based Medicine: The Sound Sleep Study."** Jo M. Solet, PhD., et al., Validating Acoustic Guidelines for Healthcare Facilities. The Center for Health Design, Research Coalition. 2010. http://www.healthdesign.org/sites/default/files/Validating%20Acoustic%20Guidelines%20for%20HC%20Facilities_Sound%20Sleep%20Study.pdf

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17. **"Elimination of an Intervention to Increase Bed Alarm Use to Prevent Falls in Hospitalized Patients,"** R. Shorr, A. M. Mion, et al. Annuals of Internal Medicine, Vol. 157, pp. 692 – 299. 2011.

18. **"Integrating the MDS 3.0 Into Daily Practice: Promoting Mobility, Reducing Falls, and Eliminating Alarms Through Individualized Care,"** Series Two, Part Four, Pioneer Network Webinar, Joanne Rader, February 12, 2012.

19. **"Leading a Fall Prevention Program Without Physical Restraints or Personal Alarms,"** Stratis Health, Quality Improvement Organization for Minnesota, Webinar Archives. April 17 & 24, 2012.

20. **"Physical Restraints and Fall Prevention; Participants will identify effective strategies to eliminating alarms without increasing their fall rate."** Healthcentric Advisors, Quality Improvement Organization for Road Island, Long Term Care Leadership Advisory Group. Providence, RI, April 24, 2012. http://www.healthcentricadvisors.org/events/256-long-term-care-leadership-advisory-group-physical-restraints-and-fall-prevention.html

21. **"Effects of an Intervention to Increase Bed Alarm Use to Prevent Falls in Hospitalized Patients: A Cluster Randomized Trial."** Ronald Shoor, MD, et al., Annals of Internal Medicine, Vol. 157, No 10, pp. 692-299, November 2012 ". . . alarms had no statistically or clinically significant effect on fall-related events or physical restraint use."

22. **"Nursing Homes in State Going 'Alarm-Free,' Liking the Results."** The Day, Connecticut. Lisa Chedekel, Published March 25, 2013.

23. **"Friendship Haven Pioneers Alarm Elimination,"** LeadingAge Iowa's Communique E-Newsletter, Vol. 9, Issue 10, May 15, 2013.

24. **"The Buzz: Facilities Are Going Alarm Free**." American Medical Directors Association Journal, Vol. 14, No. 8, Pp. 1 & 7, August 2013.

25. **"Adverse Health Events in Minnesota,"** Tenth Annual Public Report, Minnesota Department of Health, Page 106. January 2014 http://www.health.state.mn.us/patientsafety/ae/2014ahereport.pdf

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27. **"Alarm Fatigue: The Human-System Interface."** Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, *Lilly M. Guardia-LaBar MS, RN, Elizabeth Ann Scruth PhD, MPH, Judy Edworthy PhD. et al.* June 2014, Volume 28 Number 3, pp. 135 – 137.

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29. **"Best Practices for Reducing or Eliminating Alarm Use in Nursing Homes,"** Connecticut Culture Change Coalition, March 15, 2015 http://www.ctculturechange.org/index.php/alarms/

30. **"Alarms: The New Deficient Practice? Eliminating Alarms and Preventing Falls by Engaging with Life,"** Teresa Laufmann, RN, Carmen Bowman, MHS, Published by Action Pact, April 2015 http://actionpact.com/index.php/product/eliminating-alarms-and-reducing-falls-by-engaging-with-life

Balance, Strength, Exercise, Activity:

1. **"Exercise Training for Rehabilitation and Secondary Prevention of Falls in Geriatric Patients with a History of Injurious Falls."** K. Hauer, PhD., et al., Journal of the American Geriatric Society, Vol. 49, pp. 10 – 20. 2001.

2. **"Muscle Weakness and Falls in Older Adults: A Systematic Review and Meta-Analysis.**" J. D. Moreland, PhD., et al., Journal of American Geriatric Society, Vol. 52, pp. 1121 -1129, 2004.

3. **"Fall Incidence in Frail Older Women After Individualized Visual Feed-back Balance Training,"** S. Sihvonen, PhD., Gerontology, Vol. 50, pp. 411 – 416. November/December 2004.

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Correct Bed Heights, Chair Heights, Sit to Stand, Movement:

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4. **"Association between subject functional status, seat height, and movement strategy in sit-to-stand performance**." C. Mazza, et al., Journal of the American Geriatrics Society, *52*(10), 1750-1754. 2004.

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Reducing Bedside Floor Mats:

1. **"Tips and Tricks for Selecting a Bedsize Floor Mat."** S.P. Applegarth, Tampa, FL: VISN 8 Patient Safety Center of Inquiry, 2004.

2. **"The Hazards of Using Floor Mats as a Fall Protection Device at the Bedside."** A.K. Doig, and J.M. Morse, Journal of Patient Safety. 6(2):68-75, June 2010.

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1. **"Environmental & Communication Assessment Toolkit,"** Jenifer Brush, Jon Sanford, et al., Health Professional Press, 2012. www.healthpropress.com

2. **"Energize Your Interior Design for Powerful Person-Centered Outcomes,"** Lorraine G. Hiatt, Pioneer Network Annual Conference, Current Session A4, 2012.

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