

Falls Prevention: Nuts and Bolts




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
F Tag 323 – Definition: Fall

➤ Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). An episode when a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.



F Tag 323 – Accidents and Supervision Includes:

- ▶ Smoking
- ▶ Resident-to-resident altercations
- ▶ Exposure to sharps, chemicals, toxic substances
- ▶ Hot tap, hot/cold bath water and hot beverages
- ▶ Unsafe wandering, elopement
- ▶ Environmental hazards: electric safety
- ▶ Environmental hazards: insufficient lighting, glare, poor definition
- ▶ Assistive devices and equipment hazards: lifts, gait belts, canes, walkers, condition, fit, staff practices, staff education
- ▶ Bed rails/restraints/mattress fit: entrapment (bed-gap analysis)
- ▶ Choking: altered texture/thickened liquids
- ▶ Falls and related factors ←



F Tag 323 – Intent:

- To ensure the residents' environment remains as free of accident hazards as possible.
- To ensure each resident receives adequate supervision and assistance devices to prevent accidents.



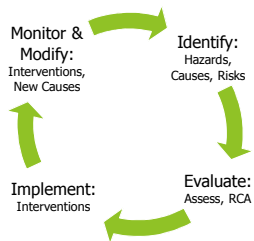
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Methods to Meet Intent of F Tag 323

- Identifying hazards, (causes) and risks (for falls);
- Evaluating and analyzing hazards, (causes) and risks (for falls);
- Implementing interventions to reduce hazards, (causes) and risks (for falls); and
- Monitoring for effectiveness and modifying interventions (for falls) as indicated.

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A Systems Approach to Meet Intent of F Tag 323



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Empira Fall Prevention Program: Background

- Empira awarded 3-year MN DHS PIPP grant; began 10/1/08
 - ~ A project to determine the root causes for residents' falls in participating SNFs and to implement interventions from evidence based findings
 - ~ Goal: Reduce QI/QMs; Falls, Depression & Anxiety, Decline in LL ADL, Decline in movement
 - ~ Reduction Goal: 5% first year, 15% second year, 20% third year
- 16 SNFs, 4 companies participate in PIPP Fall Prevent project
- Fall Risk Coordinator in each SNF reports to administrator who oversees the program – it's not a nursing program!
- Grant completion date: 10/1/11 (Program continues to date)



Empira's Fall Prevention Program

- This program is a combination of nationally recognized fall prevention, evidence-based, scientific research studies and the application of cutting edge practices to enhance residents' lives
- Empira is challenging some of the standards of practice, regulatory requirements and operational procedures for preventing falls and for providing cares and services in skilled nursing facilities



Two Tiered Approach to Fall Prevention

- Proactive (fall prevention on admission)
 - Identify individual's specific risk factors for falls
 - Actions based on specific personalized risk factors
 - Actions based on evidence and assessments
- Reactive (post falls action)
 - Investigate current falls as they occur
 - Collect factual evidence from the fall event
 - Collate, aggregate and study the causes of falls




Faulty Assessment and Incorrect Root Cause to Preventing Falls:

When a resident moves = they fall down

Prevent movement or mobility = then you prevent the fall

No!




Correct Identification to Preventing Falls; Correct Intrinsic Assessment

A resident has needs + their needs set them into motion + they are weak = they fall down

Address the resident's needs + get them physically active (encourage strengthening) = you reduce their falls



Yes!

"Not Preventing Falls - Promoting Function," Sarah H. Kagan, PhD, RN, and Alice A. Puppione MSN, RN, Geriatric Nursing, Vol. 32, No. 1, p. 55 - 57. January/February 2011.




Using root cause analysis to determine reasons of falls

➤ RCA is a process to find out what happened, why it happened, and to determine what can be done to prevent it from happening again.



3 Areas to Identify and Evaluate for Root Cause Analysis of Falls


1. Internal / Intrinsic conditions
2. Environmental / Extrinsic conditions
3. Operational / Systemic conditions



Identify Risks: Falls Risk Assessment Upon Admission


1. During the admission process identify, assess and document the individual's specific risk factors for being at a high risk for falling: diagnoses, medications, recent history of falls, predisposing causes or triggers for the falls.

Example: "Everyone is at high risk for falling. This resident, Ms. Guildermann, is at a high risk for falling because she is 65 y.o., has Meniere's Disease, suffers from occasional vertigo, meds include Triamterene."
2. Consider psychological / emotional factors; grief, depression, self imposed restriction of activity (fear of falling).
3. Assess for lower-extremity balance and strengthen status.
4. Assess for sleep/wake patterns and sleep/wake schedule.
5. Individualize admission interventions: "to keep this resident safe and minimize falling . . ."



Case Studies, New Admissions:

- Mr. S.P., 74 y.o., lives alone, recently widowed, alcohol dependent, slightly confused, easily agitated, has multiple hematomas from many falls
- Mr. A.T., 76 y.o., active, alert, visually impaired due to macular degeneration, slipped and fell on ice getting out of his son's car, fx elbow & shoulder
- Mrs. H.G., 88 y.o., early stage Lewy Body Dementia, symptoms increasing, can no longer be cared for in her AL setting



At Admission Fall Prevention Interventions



- Select roommate with similar sleep/wake patterns
- Slow, repeated orientation to room, roommate, home
- Create a room/bed area that most closely represents the resident's home environment; placement of personal items, nightstand, bed, furniture, assistive equipment within the room
- Personalize room and clearly identify room so that resident will know it is their room; pictures, items, own bedspread, own pillow, bed by door or window or access to bathroom
- Adapt room to residents' physical limitations, e.g. bed, nightstand, equipment placement, bed in relation to bathroom or door
- Create contrast; items & furniture to background area
- Set bed height to be correctly heighted to each resident – mark it
- Individualized correct footwear

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Post Fall Assessment: Model Assessments Expected and Completed for Pain, Skin Conditions, Incontinence

- ▶ Application of same standards identified and expected from F Tags; 309 (Pain), 314 (Skin Conditions), 315 (Continance) to Falls

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Would we use the same interventions for their pain?



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Would we use the same interventions for their skin conditions?



Would we use the same interventions for their falls?




Identify hazards and risks at time of falls:
A Systems Approach – Root Cause Analysis

- Sources for identifying (fall) hazards may include:
 - Admission Fall Risk Assessment
 - Post Fall Investigation: root cause analysis
 - Post Fall Huddle
 - Falls/Accident Committee
 - Environmental rounds
 - Resident needs identified from rounds
 - Medical history and physical exams
 - Ongoing assessments for Changes in Conditions
 - MDS/triggered QIs


F-Tag 323, Proper action following a fall includes:

- Ascertain if there were injuries and provide treatment as necessary;
- Determine what may have caused or contributed to the fall;
- Address the contributing factors (causes) for the fall; and
- Revise the resident's plan of care and/or facility practices to reduce the likelihood of another fall.



Identify Risks: Post Fall Assessment



- ▶ "Check, Call, Care"
- ▶ Complete the "10 Questions"
- ▶ Post Fall Huddle
- ▶ FSI: Fall Scene Investigation report completed then upload to Empira site
- ▶ Empira software program aggregates, collates, averages FSI results (modeled from MDS and QI/QM Reports)
- ▶ Facility Falls Committee Meeting



When you see a resident who has fallen, do the following:


"Check, Call, Care"

1. Immediately go to the resident, stay with the resident
2. If you are not a nurse, call for a nurse
3. Encourage the resident not to move, "Are you OK?"
4. Ask them, "What were you doing just before you fell?"
"What were you trying to do just before you fell?"
5. Begin getting answers to the "10 Questions"
6. Stay for the fall huddle, assist in getting a fall huddle started




10 Questions at the time a resident falls. Stay with resident, call nurse.


1. Ask resident: Are you ok?
2. Ask resident: What were you trying to do?
3. Ask resident or determine: What was different this time?
4. Position of Resident?
 - a. Did they fall near a bed, toilet or chair? How far away?
 - b. On their back, front, L side, or R side?
 - c. Position of their arms & legs?
5. What was the surrounding area like?
 - a. Noisy? Busy? Cluttered?
 - b. If in bathroom, contents of toilet?
 - c. Poor lighting – visibility?
 - d. Position of furniture & equipment? Bed height correct?
6. What was the floor like?
 - a. Wet floor? Urine on floor? Uneven floor? Shiny floor?
 - b. Carpet or tile?
7. What was the resident's apparel?
 - a. Shoes, socks (non-skid?) slippers, bare feet?
 - b. Poorly fitting clothes?
8. Was the resident using an assistive device?
 - a. Walker, cane, wheelchair, merry walker, other
9. Did the resident have glasses and/or hearing aides on?
10. Who was in the area when the resident fell?



Identify: Post Fall Huddle




- Performed immediately after resident is stable
- Charge nurse has all staff, working in the area of the fall, meet together briefly to conduct RCA
- Review “10 Questions” with staff
- Also ask staff:
 - “Who has seen or had contact with this resident within the last few hours?”
 - “What was the resident doing?”
 - “How did they appear? How did they behave?”
- Begin completing the FSI form during the huddle




Identify: Fall Scene Investigation (FSI) Report

- Data collection tool used to investigate and determine RCA
- Completed soon after the fall occurs and/or during the fall huddle
- Completed by nurse in charge, on duty at time of the fall



Let's look at the FSI report



F - Tag 323, Systems Approach: Evaluation and Analysis

- The facility examines data gathered through identification of hazards, causes and risks, and
- Applies it to the development of interventions to reduce the potential for accidents.
- Interdisciplinary involvement is a critical component of this process.

Fall Committee Meeting

- Meets weekly at same time and day
- All appropriate departments represented
- Charge nurse & nurse aide from fall site are "ad hoc"
- Have all relevant information available; FSI report, MAR, resident's chart, fall huddle findings, hourly roundings
- Agenda:
 - New falls;
 - Review FSI report, huddle findings, review RCA
 - Review interventions – Do they match the RCA? Are they weak, intermediate, or strong interventions? Suggestions?
 - Status of residents from previous falls and interventions?
 - Are systems and operational changes needed?
- Status reports and audits; alarm reduction, med reduction, wake at will, Fall Summary, QVQM reports, falls per 1000

Identification of Causes of Falls: Intrinsic - Internal, Extrinsic - Environmental, Systemic - Operational

- Extrinsic:
 - Noise; Alarms, staff talking-paging, TVs. Poor environmental contrasts & visibility. Room/bed assignment. Placement of furniture & personal items, clutter, footwear, lighting, bed heights
- Intrinsic:
 - Needs not met = 4 Ps; Pain, Potty, Position, Personal Items + Sleep fragmentation. Medications (type, amt, dose, number, effects). Reduced mobility; poor balance, strength, endurance.
- Systemic:
 - Noisy/busy times of day; shift changes, meal times. Days of week. Locations of falls; rooms, halls, congregate areas. Types of falls; transferring, walking, reaching. Staffing levels. Routine assignments; cleaning, stocking, repairing.

External lesson learned:

**If we can stop the noise,
then we can reduce the falls.**



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Internal lesson learned:

**If we can stop disturbing sleep,
then we can reduce the falls.**



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Operational Lesson Learned



**If we can align operations and
systems to support resident
preferences and improve quality
of life, then we can reduce falls.**



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Interventions

- F Tag 323, §483.25(h) Accidents: “Implement interventions to reduce hazards (causes) and risks.”
- Definition of Medical Interventions: patients receive treatments or actions that have the effect of preventing injury, illness and/or prolonging life.
- Interventions must match the causative agents of the injury, illness, disease and/or conditions.



A Systems Approach: Implementation of Interventions


- The process includes:
 - Communicating the interventions to all relevant staff;
 - Assigning responsibility;
 - Providing training as needed;
 - Implementing and documenting interventions; and
 - Ensuring that interventions are implemented.



Hierarchy of Interventions

- National Center for Patient Safety’s “Hierarchy of Actions”, a classification of corrective actions and interventions:
 - **Weak** – actions that depend on staff to remember their: training, policies, assignments, regulations, e.g. “remind staff to . . .” or “remind resident to . . .”
 - **Intermediate** – actions are somewhat dependent on staff remembering to do the right thing, but tools are provided to help the staff remember or to help promote better communication, e.g. lists, pictures, icons, color bands
 - **Strong** – does not depend on staff to remember to do the right thing. The tools or actions provide very strong controls, e.g. timed light switch, auto lock brakes

* To be most effective: interventions need to move to stronger actions rather than education or memory alone.



Interventions for Extrinsic Causes of Falls:

- ▶ Identify, reduce and eliminate causes of noise; alarms, staff talking & paging, TVs
- ▶ Reduce busy times; sift changes, meals
- ▶ Reduce noisy areas; nurses' stations, dining rooms, kitchens, day rooms
- ▶ Increase visibility; contrast environment, better lighting
- ▶ Create surroundings aligned with resident personal preferences
- ▶ Reduce clutter; floor mats, rugs, furniture placement

Interventions for Intrinsic Causes of Falls:

- ▶ Address needs for 4Ps - Position, Potty, Pain, Personal Items
- ▶ Prevent Sleep Fragmentation - Restorative Sleep Vitality Program
- ▶ Increase daytime mobility - Improve balance, strength, endurance through engagement in resident preferred activities, physical & occupational therapies, ADLs
- ▶ Reduce Medications - types, dose, times, number, cascade effects

Interventions for Systemic Causes for Falls:

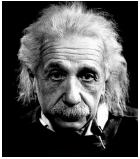
- ▶ Improved orientation of residents to facility
- ▶ Select and arrange resident's room to align with resident preferences and routines
- ▶ Align staff times, staff assignments, staff schedules, # of staff, to support resident needs and preferences
- ▶ Protect night time sleep
- ▶ Provide more engaging activities throughout the day, especially in late afternoons and after dinner

A Systems Approach: Monitoring and Modification

- Monitoring and modification processes includes:
 - Ensuring that interventions are implemented correctly and consistently;
 - Evaluating the effectiveness of interventions;
 - Modifying or replacing interventions as needed; and
 - Evaluating the effectiveness of new interventions.

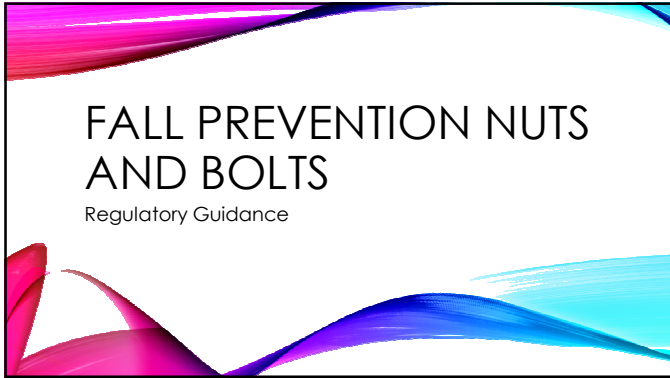
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“If I had an hour to solve a problem, I'd spend 55 minutes thinking about the problem and 5 minutes thinking about solutions.”



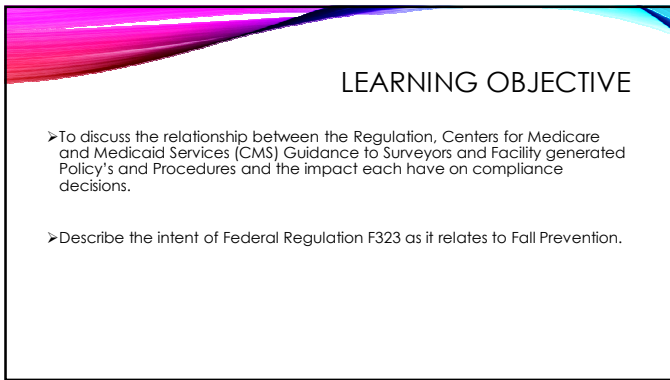
— Albert Einstein

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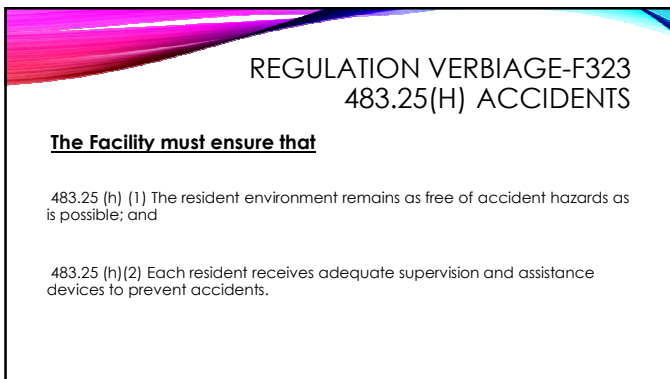
FALL PREVENTION NUTS AND BOLTS

Regulatory Guidance



LEARNING OBJECTIVE

- >To discuss the relationship between the Regulation, Centers for Medicare and Medicaid Services (CMS) Guidance to Surveyors and Facility generated Policy's and Procedures and the impact each have on compliance decisions.
- >Describe the intent of Federal Regulation F323 as it relates to Fall Prevention.



REGULATION VERBIAGE-F323 483.25(H) ACCIDENTS

The Facility must ensure that

483.25 (h) (1) The resident environment remains as free of accident hazards as is possible; and

483.25 (h)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

CLARIFICATION OF TERMS

- State Operations Manual (SOM)
- Appendix PP-Part of SOM Regulations/Guidance to Surveyors
- Investigative Protocols
 - CMS instructions on how to investigate/determine compliance with select regulations.

INTENT

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.

FALL PREVENTION

- Identify and assessment of hazards/risks
- root cause of fall or potential falls
 - Evaluating and analyzing hazards/risks
 - Implementing interventions
 - Monitoring effectiveness and modifying interventions when necessary.

FALL PREVENTION CONT'D

Development of Care Plan

- Individualizing approaches and treatment
- Expected Outcomes
- Monitoring Effectiveness
- Plans for reevaluation
- Staff knowledge of Plan of Care

AVOIDABLE VS. UNAVOIDABLE

Avoidable means that an accident occurred because the facility failed to

- Identify resident was at risk for fall
- Evaluate
- Implement interventions
- Monitor and modify interventions

Examples include

- Encourage staff reporting
- Toileting programs
- Medication reviews
- Activities participation
- Change in visitations
- Room changes
- Fall programs
- Non-skid soles
- Balance Assessment test
- Increased supervision
- Alarms (See next slide)
- Fall mats
- Low bed
- Hip protectors
- Eating times evaluated
- Therapy evaluations
- Assess environmental factors, etc.

ALARMS

- **NEWEST EXPECTED CMS GUIDANCE:**
- Facility efforts to reduce use of alarms have shown falls actually decrease when alarms are eliminated and replaced with other individualized interventions
- Surveyors must evaluate whether any negative outcomes occurred as a result of alarm use
- Facility shall not be considered noncompliant with F323 solely based on choosing not to use or activate the alarms

ALARMS

- Surveyor must find evidence of other interventions in the care plans for residents at risk for falls
- Surveyors must find evidence that staff analyzed information necessary to provide appropriate care and services to prevent falls
- Alarms may meet the definition of a restraint as the alarms may restrict freedom of movement and may not be removed easily by the resident

AVOIDABLE VS. UNAVOIDABLE
CONT'D

Unavoidable means that an accident occurred despite the facility's efforts to

- > Identify risks
- > Evaluate
- > Implement interventions
- > Monitor and modify interventions

NEW ADMIT RESIDENTS

When a resident is already assessed as a fall risk the facility must

1. Implement interventions, including adequate supervision, consistent with the resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of a fall
2. Facility's are obligated to provide adequate supervision to prevent accidents, based on assessed resident needs and identified hazards in the resident's environment

ESTABLISHED RESIDENTS

When an established resident at the facility has had a change in condition and has been assessed to be a high risk for falls the facility is obligated to

- > Reassess
- > Implement interventions
- > Supervise based on assessed needs
- > Monitor and modify interventions as needed

GUIDANCE TO SURVEYORS

To determine if the facility provided care and services, including assistive devices as necessary to prevent avoidable accidents and to reduce the residents risk to the extend possible.

INVESTIGATIVE PROTOCOLS

Observation

1. Alarms (if implemented are they turned on and functioning),
2. Low beds (if high or low),
3. Restraints (physician's orders, care plans, evaluations, reduction evaluation/assessment),
4. Fall mats (if in place when resident in bed),

INVESTIGATIVE PROTOCOLS

Observation CONT'D

5. Positioning and activity of resident (in bed, tilt back wheelchairs, geriatric lounge chairs, standard wheelchairs),
6. Bruising, casts, skin tears,
7. Environmental Factors,
8. Call light (within reach, response time),
9. Resident heard calling out for "Help", etc..

INVESTIGATIVE PROTOCOLS

Interview

1. Interview residents, family, staff see if reported decreased help from staff, decreased call light response times, if any hazard situations occurred, see if facility followed procedures correctly

INVESTIGATIVE PROTOCOLS

Record Review

1. Determine if facility assessed and if assessment is consistent with clinical record
2. Example; Behavior's identified, impairments addressed, medications reviewed, history of falls addressed, care plans updated and followed, facility policy reviewed, hear, vision, gait disturbances addressed, CENA care guides updated

FACILITY POLICY

Determine if facility policy's reflect the identification of risk/hazards, evaluating and analyzing information, implementing and monitoring interventions to determine if modification is needed.

Through culture change initiatives, team approach and learning about the resident, avoidable falls can be reduced.

Thank you.

Questions?
