PROACTIVE PRACTICES TO PREVENT FALLS

APRIL 11, 2023

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CHAR MURPHY, DOBIE ROAD CNO

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CONFLICT OF INTEREST STATEMENT

CARMEN BOWMAN OF EDU-CATERING HAS A FINANCIAL RELATIONSHIP WITH ACTION PACT, INC. WHICH HAS BEEN MITIGATED.

JENNIFER VANWORMER RN
STATE SURVEYOR
LANSING SOUTHWEST TEAM

PRE-SURVEYING FOR FALL PREVENTION

- First and foremost- **THANK YOU FOR WHAT YOU DO!** Each and every one of you play an essential role in preventing falls, falls with injury, and complications from falls leading to death.
- Trends noted by the State Survey Agency indicate that F689 – falls remains one of the top ten citations for more than 10 years across most States.
- Falls and safety concerns are one of the **TOP TEN** written citations in Michigan**. Preventing falls allows for greater outcomes for both the residents and the facility**.
- This is our (surveyors) time to help you understand and incorporate proactive techniques to prevent falls, and understand the falls investigations from surveyors perspective and **knowledge of F689.**

INDEPENDANCE

Falls are the main reason older people lose their independence.

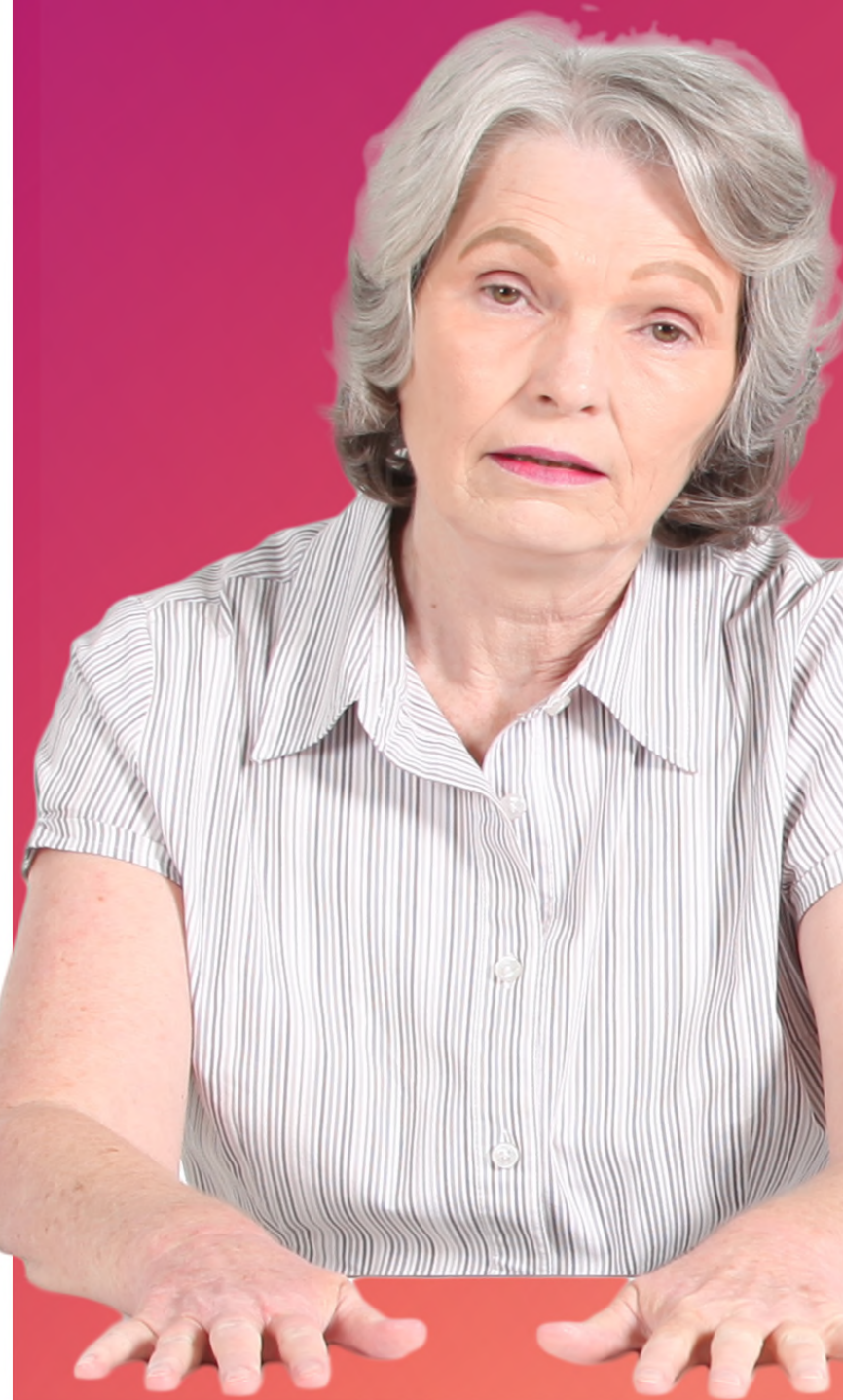
Major adjustment mentally & physically.

Falls can be devastating and are the leading cause of injuries in older adults. 1/10 falls results in injury, such as a hip fracture or head injury, which requires hospitalization. In addition to the physical and emotional pain, it may take at least a year recovering in a long-term care.

Some are never able to live independently again.

STATE OPERATIONS MANUAL

- #1. PROACTIVE APPROACH – "State Operations Manual" (SOM). F689
- #2. ACUITY LEVEL post Covid-19- Isolation, depression, communication difficulties.
- Surveyors vs LTC staff- become a surveyor in your home –utilize F689 –**CE Pathways** which are tools to assist in prevention of falls.



PREVENTION VS. INTERVENTION CARE PLANS

- Interventions- something has already happened-intervene-(falls)
- Prevention-Proactive approach before a fall(s) occur.

• The resident is at risk for falls related to: (a lot of comorbidities) • To reduce the risk of serious injury in the event of a fall through the review date.

<u>2-INTERVENTIONS</u>

• Be sure the resident's call light is within reach and encourage the resident to use it or assistance as needed.

• Provide activities per the activity care plan to minimize potential for falls.

HOW CAN I HELP YOU?

- **BACK TO THE BASICS**
- STOP!
- LOOK!!--- BOTH WAYS
- LISTEN!!!
- HELP ME!!!!
- THANK YOU!!!!!

IDT-AUDITS-PROACTIVE APPROACHES

Interdisciplinary team-IDT- again, all hands-eyes on deck.

Surveying for yourself. When the IDT does rounds (caring partners, angel eyes etc) what exactly are you looking for?.

Surveyors enter the home- call lights, walkers, water out of reach staff not on units.

Who audits the auditing IDT members to ensure these approaches are completed and accurate per person centered care plan.

OBSERVATIONS

EXAMPLES

SCENARIOS

- During a recent survey I observed a resident in their room. Call light was out of reach.
- Resident was crying out for help “Help, I need some help”
- Staff in an activity room (the next room over, could hear the resident) decorating their own door for a Christmas door décor competition.
- We waited, after 10 minutes a CNA walked by, and entered the room. The activity staff noticed the CNA, came out of the room and said
- “I WAS GOING TO HELP, BUT I DIDN’T KNOW WHERE THE ““HELP ME”” WAS COMING FROM”

FALLS WITH INJURY-HOSPITALIZATION

- Resident entered facility due to health issue, lightheadedness and a fall at home with no injury.
- Within 2 days of being in the home person falls-unwitnessed at lunch time-outside of dining room, in front of nurses station, and near DON's office.
- FRI-investigation reports care plan appropriate and root cause determined to be Residents orthostatic hypotension (low blood pressure) can cause lightheadedness.
- Surveyors investigation- according to MDS assessment, Physical Therapy recommendation, and staff interviews. The person needs1 person to assist.
- ACTUAL ROOT CAUSE-THE PERSON WAS ALONE.

FALLS LEADING TO A DEATH SCENARIO

- Resident had multiple falls- was blind-used a walker able to ambulate to and from bathroom, and had a lift chair.
- Resident known to fidget with the remote for the lift chair, ejecting themself out of the chair on numerous occasions-multiple falls.
- Resident ejected themself out of chair, fell breaking nose, cheek bones, and orbital facial fractures.
- FRI-reported -Care plan deemed appropriate. No intervention or mention of lift chair.
- Entered facility- resident no longer able to ambulate, entire face broken and bruised.
- Next week-enter-resident again ejected self out of chair-death cert-complication from multiple facial fractures-less than a week after initial FRI was reported.

WHOM IS RESPONSIBLE FOR THE SUPERVISION

- Often times we notice when staff take their breaks, no other staff come to cover the units, AND multiple staff on break at the same time.
- Where are high risk, at risk and history of falls, multiple falls or new admissions placed in the neighborhoods, rooms, distance from nurses station-acclimation to the call light.
- Who is ensuring that units are never left completely alone with no staff. How to let all staff know what neighborhood needs more assistance due to acuity levels.

ROOT CAUSE FOR FALLS

ROOT CAUSE ANAYLSIS- WHY/HOW DID THE RESIDNET FALL?

When investigating falls most common is the residents-non compliance, unwitnessed, behaviors, didn't use call light and or lowered to the ground.

When a resident falls it's typically due to a lack of staffing, adequate supervision, not having enough education on how to use the call & light- turning it back on until need is met.

MAINTAINING FUNCTIONAL ABILITY

- Once an older adult has fallen, there is a significant increased risk that he or she will fall again under similar circumstances...a major concern with a fall is the subsequent fear of falling that can occur.

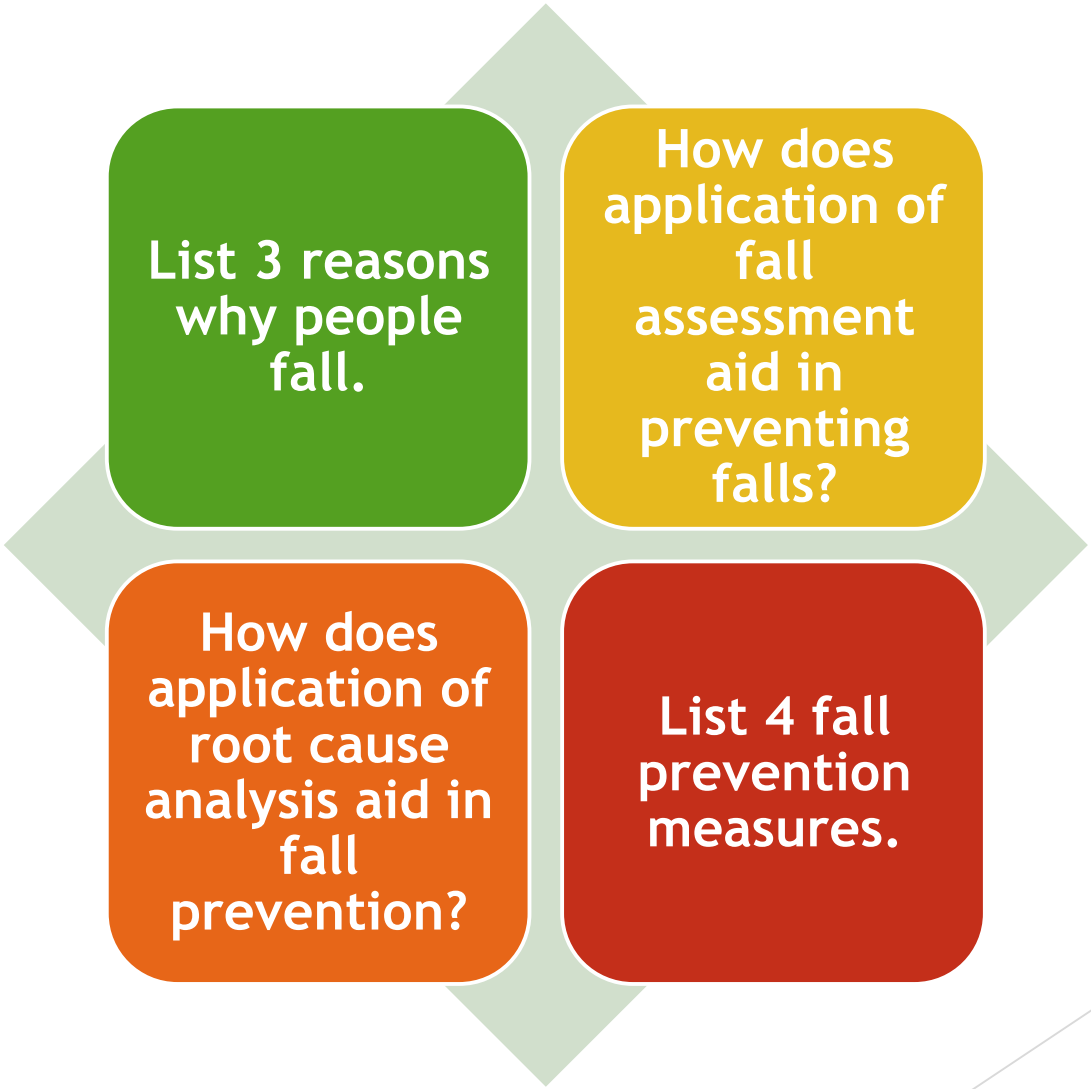
- Fear of falling has been cited as one of the most serious and debilitating psychological consequences of a fall...The intention of a fall prevention program in acute care is not only to prevent falls, but also to provide patients with nursing care that focuses on improving and maintaining the functional ability of older residents.

Incentives-Challenge

- Receptionists, activity aides, and other staff that are CNA who are no longer working the floor-can assist when needed-another staff-unqualified can be taught to answer the phones.
- CMS- SCENERIO FOR A FALL how the home took action
- Person was falling same time every day. Nurse parked themselves at the end of the hall. Nurse was passing medications- outside the persons room, crushing meds→
- Sounded like knocking- woken up- move cart away from the residents room falls stopped.
- Next joint provider –HAVE YOUR FALLS DECREASE BY USING THESE PROACTIVE APPROACHES?

Proactive Approach to Fall Prevention

Learning of Objectives



Causes of Falls

- Age- 65+
- Gender- Females due to hormone imbalance
- Cognitive impairment
- Polypharmacy
- Gait instability
- Reaching for objects

Do alarms prevent falls?

Our experience is that alarms do not prevent falls

By the time the alarm has sounded, the individual has already fallen

Fall Assessment

All new individuals that are admitted have a fall assessment completed

Fall assessments are completed quarterly, and if that person has had a significant clinical change in condition

Components of a Fall Assessment

10 Point Questionnaire

Any falls in the last 90 days- yes/no	Date of last fall	Any recent clinical changes- yes/no	Behavioral changes- yes/no	Incontinence of bowel or bladder- yes/no	Difficulty with walking- yes/no	Any changes in blood pressure- Drop >20 mm Hg yes/no	Age- 85+- yes/no	Recent med changes in the last seven days- yes/no

If score >9, person is considered at risk for falls

Morning Clinical Meetings and getting to Root-Cause -Analysis

Clinical team reviews each individual fall, takes a deeper dive get to the “whys”

Why did they fall

When did they fall

What caused the fall

Are there triggers, correlations

Team develops an approach to prevent that fall from occurring again

May do staff education

Manager evaluates whether the approach was effective

Approaches to Fall Prevention

- Bathroom upon rising, before and after meals, before going to bed
- Keep essentials items within reach
  - Phone, call light, water/juice
- Purposeful check ins, offer bathroom if awake at night
  - Regular Check ins on those known to go for regular walks
  - Keep urinals emptied
  - Spot check that the preventative measures are in place.
    - Low beds, mats at bedside etc.
- Personalized engagement
- Pain management

Restorative Services

- In order to maintain functional ability, having an individualized restorative service in place, helps to reduce falls.

Evaluation

- We are a large building, periodically our managers go back and evaluate the effectiveness of the preventative measures that are in place

Alarm-Free Community

- Our building is quieter
- Our experience is that alarms do not prevent falls

References

Agostini; J.F. Barker D;

Prevention of Falls in Hospitals and Nursing Homes.

Chapter 26; A Critical Analysis of Patient Safety Practices

Department of Veteran Affairs;

National Center for Patient Safety Tips on Fall Prevention

March 29th, 2002

PROACTIVE PRACTICES TO PREVENT FALLS

CARMEN BOWMAN,

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IS LTC KNOWN FOR BEING REACTIVE OR PROACTIVE?

REACTIVE

WHICH WOULD YOU LIKE TO BE KNOWN FOR … REACTIVE OR PROACTIVE?

PROACTIVE

CMS QUALITY OF CARE. F689 ACCIDENTS. FALLS.

- Individual facility efforts to reduce use of alarms have shown falls actually decrease when alarms are eliminated and replaced with other interventions such as purposeful checks to proactively address resident needs, adjusting staff to cover times of day when most falls occur, assessing resident routines, and making individualized environmental or care changes that suit each resident.
- Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls.

WHAT IS THE MAIN REASON FOR FALLS IN YOUR COMMUNITY?

BORED

NEED BATHROOM

REACHING FOR SOMETHING

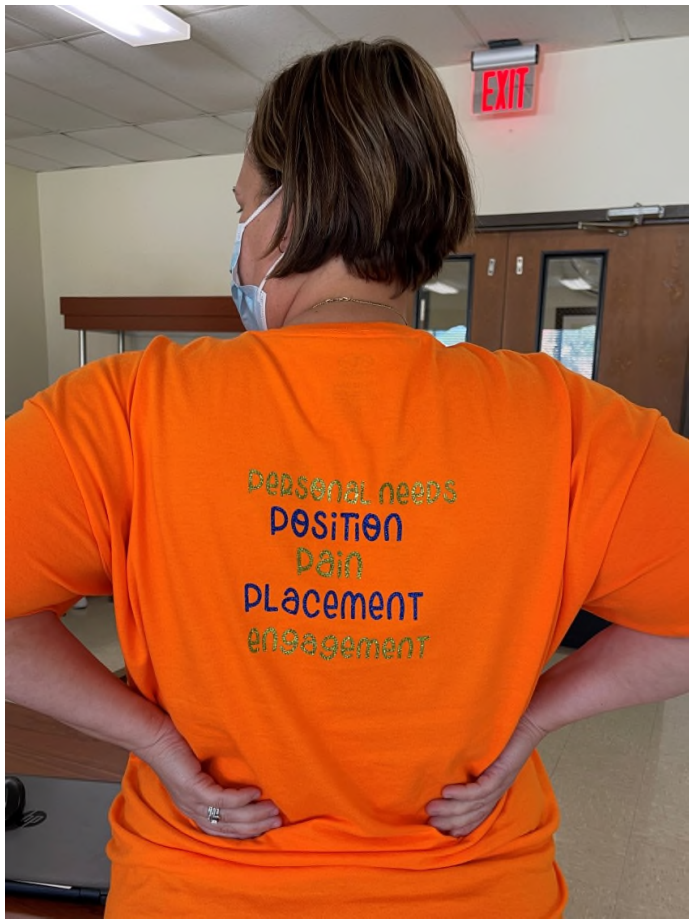
"ANTSY"

PROACTIVELY ANTICIPATING NEEDS, PARTICULARLY BATHROOM PREVENTS FALLS

(REPLACING TOILETING)

PROACTIVE CHECKING IN WITH RESIDENTS BY ALL PREVENTS FALLS

Falls do not belong to nursing.



The 4 Ps and an E

- Pain
- Positioning
- Personal items
- Personal needs (= bathroom)
- Engagement

"We now check in with the resident, instead of checking the clock."

MEANINGFUL ENGAGEMENT, IN RESIDENT ROOMS, & ON THE PERSON, PREVENTS FALLS

Most falls take place in the person's room

What would meaningfully engage you?

HONORING SLEEP/ NATURAL AWAKENING & OPEN DINING

BEING WELL RESTED LEADS TO … FEWER FALLS

Outcomes

Pressure ulcers have decreased
Falls have decreased
Supplements have decreased
Sleep promotes healing
Body heals naturally
Retention rate increased
Overtime decreased
Bonuses just to work not needed
Decreased labor needs, more efficient

Westward Heights WY Culture Change Project 4/22-3/23 1 off 5 mini-documentaries on YouTube

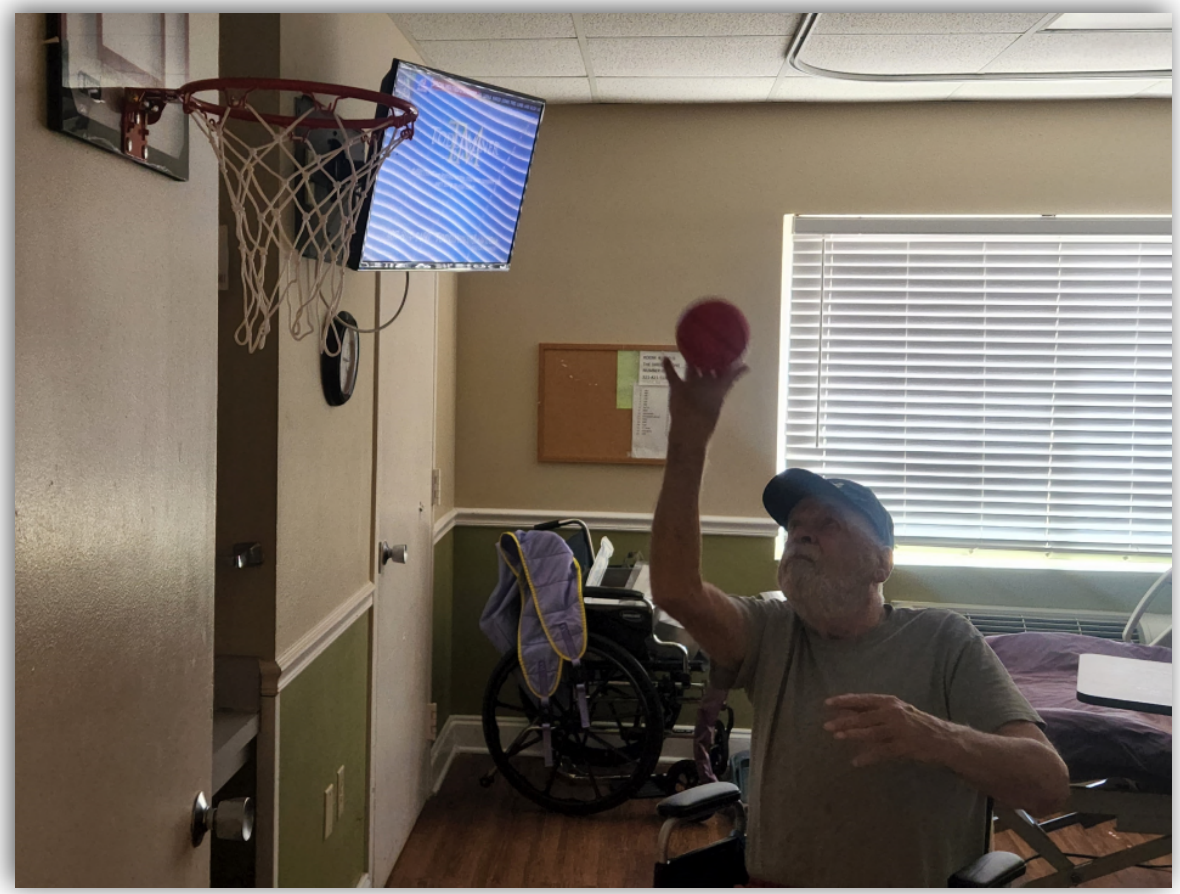
IMMOBILE OR MOBILE…?

WHICH ARE WE KNOWN FOR?

A PERSON STANDS, WHAT DO WE TELL THEM TO DO?

"PLEASE SIT DOWN, MR. SMITH"

= IMMOBILITY MINDSET



FL Grant Project Nursing Home
Gentleman falling. Discovered use to be a basketball coach and loves sports. Needed movement. Individualized increased movement.
No falls since.

SHIFT

FROM institutional culture = fall prevention at any cost

TO individuals-first culture = intentional increased movement

PROACTIVE PRACTICE:

INCREASED INDIVIDUALIZED MOVEMENT

PREVENTS FALLS

REPLACING ALARMS WITH PROACTIVE PRACTICES FL CMP GRANT PROJECT

- Had Fall Focus Room with group activities to "keep a closer eye on" those at risk.
- Realized was generic and a group mindset - the same amount of stimulation.
- Realized not individualized, for some too much stimulation.
- Realized ***a group cannot be all to all people… ever***.
- "I don't want to go to the Fall Focus Room. **You go there to be punished if you fall**."
- With such a negative connotation and not individualized, we need to go after what motivates one to move individually/*no more fall focus room*.

One year grant project 7/20 to 6/21, month totals
Alarms 6 to 0, Falls 41 to 8; Falls with Major Injury: 3 to 0

MORE PROACTIVE PRACTICES TO PREVENT FALLS …

- Getting outside – sunshine – Vitamin D
- Sundowning means the person needs SUN
- Proactively supporting each person's circadian rhythm

- Lavender leads to fewer falls
- Consistent/dedicated staffing
- Individual music

EVEN MORE PROACTIVE PRACTICES TO PREVENT FALLS

Very individualized care plan with detailed, individualized, not generic, fall prevention strategies

Care plan *highest practicable physical, and mental, and psychosocial well-being* and how to achieve or maintain it per Tag 689 Accidents, Falls and 655 Comprehensive Person-Centered Care Plan.

Use the environment to our advantage to prevent falls

Discover & plan for each person's domains of wellbeing, now at Tag 679 Intent: *security, autonomy, growth, connectedness, identity, meaning and joy!*

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