Managing your Fall Program with Monitoring and Documentation.

Is it Working?

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- Look at the background/philosophy of fall prevention programs.
- Compare resident risk factors by utilizing a validated fall risk assessment tool. Available tools include: Morse Fall Risk; Jefferson Fall Risk Assessment and Intervention Tool; MDS Balance During Transitions and Walking Algorithm.
- Discuss the benefits of individualized monitoring and documentation before and after a fall occurs.
- Learn to assess whether your fall prevention program is working or needs to be re-evaluated.
Falls are the single most significant adverse event experienced in hospitals, and one of the most significant adverse events in the post-acute area.

2-4% of all patients fall, and 2-6% of those falls result in a serious injury, such as a fracture.

In the US, *one out of every 3 people aged 65 and older falls each year*. In the post-acute long term care area, where most residents are age 65+, this number is likely to increase.
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- Falls are a leading cause of traumatic brain injuries and morbidity, occurring regularly among patients in acute care facilities.
- According to the Centers for Disease Control and Prevention (CDC), the medical cost of fall-related injuries is currently $20.2 BILLION, annually. By 2020, that number is expected to rise to $32.4 BILLION.
The CDC reports that in 2003 more than 13,700 people aged 65 and older died of fall-related injuries, and another 1.8 million were treated in emergency departments for nonfatal injuries related to falls.

This data was based on a population that did not yet include the Baby Boomer generation, just now starting to arrive in the post-acute setting—and in whom we’re seeing an increase in co-morbidities.

There is no single FALL PREVENTION program that works for all patients, or in every healthcare setting.
Changes in payment policies from the Centers for Medicare and Medicaid Services (CMS) will take affect soon. Hospitals no longer be compensated for treatment of “reasonably preventable” conditions that occur during patient stays (including injuries from patient falls).

Similar changes in payment policies are being discussed for the post-acute sector in the form of changes to Medicare and Medicaid reimbursement related to care and certain criteria. An example would be denial or reduced payment when readmission to hospital occurs within 30 days (for same condition).
Fall prevention goal: Reduce the risk of harm resulting from falls.

- Implement a fall reduction program including an evaluation of program effectiveness.

Remember:

- There is no one-size-fits-all solution to the problem of preventing falls.
- BUT, there is one primary goal every healthcare provider should work toward: PREVENTION.
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Prevention:

- Plan care using screening and assessment tools.
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**Question:**

What is the purpose of conducting a fall risk assessment on all residents?

- To outline the approach to managing residents who are at risk for falls.
- To provide staff with guidance for decisions regarding fall avoidance.
- To make work for the nurses as they have very little to do!
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Answer:
1 and 2 (You thought it was 3, didn’t you?)
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- A fall prevention/management program requires a planned and coordinated effort from all staff, from the highest administrator to the housekeeping staff, and all other health professionals such as pharmacy, therapy, psychotherapy.

- Concerns about a resident who could or does fall should not be confined solely to the nursing staff.

- A committee (group) of diverse individuals should assist in establishing the fall management program.
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- Fall monitoring and prevention programs can be configured in different ways, but in the end all programs/systems are based on same basic principals.
- Here, we’ll take a look at the basic steps utilized in establishing such a program.
- We do need to look at the person for program individualization, but it’s also important to utilize evidenced-based tools to ensure consistency (taking care not to utilize subjective data according to different care givers background or ideology).
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6 Basic Areas Of A Fall Prevention/ Monitoring Program:

1. Administrative support
2. Environmental safety checks of facility
3. Assessment/problem analysis
4. Monitoring
5. **Staff education** (ongoing, and as new residents arrive)
6. Interdisciplinary **ASSESSMENT** team
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Step 1: Administrative Support

Administrative support is needed as there will be expense involved in the prevention/monitoring program, including:

1. Interdisciplinary assessment team time
2. Possible facility modifications (minor or major)
3. Replacement of unsafe or out-of-date beds & mattresses
4. Fall intervention equipment
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Step 2: Environmental Safety Checks of Facility

Conduct environment checks on all areas within each unit.

- Use a team when conducting, as different people notice different hazards.
- Conduct checks at different times of the day.
- Conduct checks on different days of the week.
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Step 3: Assessment/Problem Analysis

- Use an evidence-based fall risk assessment form.
- Decide on a required time frame for completion of assessment form: upon admission; after a fall; and after any significant change in condition.
- Establish a timeframe for completing assessment form.
Step 3: Assessment/Problem Analysis (continued):

Characteristics of a good fall risk assessment tool:

- It is quick and easy to use.
- It takes into account common factors related to falls (functional & environmental assessment).
- It identifies residents “at risk” or at “high risk” of falling.
- It prompts staff to initiate referrals for further in-depth inter-disciplinary assessments.
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Step 3: Assessment/Problem Analysis (cont.)

- Should specify immediate actions or interventions aimed at fall avoidance.
- Should include conducting fall risk assessment on each resident within a specified time frame upon admission (for example, within 2, 8, or 24 hours?).
- Should determine how frequently to reassess if fall risk assessment indicates a resident is at high-risk (every shift for so many days, daily, weekly).
- Should include systematic updating of risk assessment (monthly, quarterly, with MDS).
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**Step 4: Monitoring**

- Evaluate resident progress (daily, weekly, monthly, quarterly, and with MDS).
- Ensure it is interdisciplinary not siloed to one person or department.
- Have in place a system for ensuring details of all falls are available to all staff (to heighten awareness).
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Step 5: Staff Education
(ongoing and as new residents arrive)

- Should include in-services, small groups, and orientations.
- Instruct on how to identify a fall-prone resident.
- Define exactly what is considered a fall?
- Establish how to report a fall.
- Discuss what fall prevention strategies used within the facility, and for specific residents.
- Look for ways to identify prevention strategies that work.
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**Step 6: Assemble an Interdisciplinary Assessment Team**

- Takes into account the expertise of staff from various areas of expertise to assess how to manage “problem” “fall risk” residents.
- Responsible for systematically reviewing fall reports.
- Assesses for institutional patterns regarding falls (certain areas, halls, times, staff etc.).
- Members of the team include various staff disciplines: fall prevention nurse, geriatrician, PT, pharmacist, and OT.
REMEMBER:

The goal of this team is to develop strategies for preventing a fall, **BUT** if a fall has already occurred—*the focus for that resident shifts to developing individualized strategies to prevent a reoccurrence.*
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Morse fall risk form (in packet) or see website:

http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf
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MDS Balance During Transitions & Walking Algorithm

- **Question:** How many of us utilize the MDS as part of our fall prevention and monitoring program?
Section G0300: Balance During Transitions and Walking

Steps for Assessment

- Complete this assessment for all residents.
- Throughout the 7-day look-back period, interdisciplinary team members should carefully observe document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed, and from bed to wheelchair (for residents who use a wheelchair).
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Section G0300: Balance During Transitions and Walking

Question: What is involved in this area of the MDS and can you incorporate it into your fall prevention program?
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- Before beginning the activity, explain what the task is and what you are observing for.
- Have on-hand any assistive devices the resident normally uses.
- Start with the resident sitting up on the edge of his or her bed, in a chair or, in a wheelchair (if he or she generally uses one).
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- Ask the resident to stand up and stay still for 3-5 seconds. Moving from seated to standing position (G0300A) should be rated at this time.
- Ask the resident to walk approximately 15 feet using his or her usual assistive device. Walking (G0300B) should be rated at this time.
- Ask the resident to turn around. Turning around (G0300C) should be rated at this time.
- Ask the resident to walk or wheel from a starting point in his or her room into the bathroom, prepare for toileting as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. Moving on and off toilet (G0300D) should be rated at this time.
- Ask residents who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. Surface-to-surface transfer should be rated at this time (G0300E).
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AGAIN - remember just like other fall risk assessment tools: the MDS contains some but not all of the information relevant to assessing fall risk. There is no single tool that is going to work. Having a system/program in place is the answer.
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BASIC Factors to Consider in a Fall Prevention/Monitoring Program

PLEASE CALL DON'T FALL

Your safety is important to us. If you need to get up, use the call button for assistance.
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Intrinsic Risk Factors:

- History of falls
- Mental status
- Vision impairment
- Medications
- Post-prandial hypotension
- Lower extremity weakness
- Impaired mobility
- Assistive devices
- Toileting needs
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Non-modifiable Intrinsic Fall Risk Factors:

- **Gender:** Women fall more often and are almost 3 times more likely than men to require hospitalization for a fall-related injury.

- **Race:** Caucasian people have the highest risk of falling. Caucasian men have the highest rate of fall-related deaths, followed by Caucasian women.
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Non-modifiable Intrinsic Fall Risk Factors:

- **Age:** Falls are the most common injuries in people 65 and older. Greater than 60% of people age 75 and older die from a fall. 50-75% of all residents in a longterm care facility fall each year.

- **History of Falls:** If the resident has had a previous fall, their likelihood of another fall doubles or even triples. Family history of falls increases resident’s chance of falling.
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Extrinsic Risk Factors:
- Equipment issues
- Slippery or wet floors
- Raised beds
- Inadequate assistive devices
- Lack of toilet grab rails
- Malfunctioning nurse call systems
- Use of full-length side rails
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Patient Risk Factors:

The two most frequently-reported risk factors for falls include mobility issues and poor health status.
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Mobility Related Risk Factors:

- Gait abnormalities
- Poor balance
- Postural instability or impairment of gait and balance. Residents with both gait and balance difficulties are 3 times more likely to fall
- Lower body weakness especially in legs (residents with leg weakness are at 5 times greater risk of falling).
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Mobility Related Risk Factors *(Continued)*:

- General weakness
- Inadequate trunk muscle strength
- Joint and muscle stiffness.
- Limited range of motion
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Poor Health Status—Medical conditions that increase fall Risk:

- More than 1 chronic dx of ANY kind
- Vascular disorders
- Neuromuscular Disorders
- Musculoskeletal disorders
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Additional medical conditions that increase fall risk:

- Neurological disorders
- Sensory loss
- Lung diseases
- Bowel or urinary urgency or incontinence
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Actions to take post-fall:

- Rapid response to a fall is a critical first step in your fall investigation—and to ensuring that the right post-fall intervention(s) are put in place.

- This is where critical thinking comes into action. A number of things need to be determined simultaneously, which can be daunting (while we are taking care to ensure the resident is safe, it’s easy to forget to look at the area where the fall took place and ask appropriate questions of the resident and any witnesses).
Questions to ask post-fall:

- Why did the resident fall? Is it due to a medical or neurological sudden onset, heart attack, stroke.
- Why did the resident fall? Is it due to an environmental hazard?
- Why did the resident fall? Ask the resident what happened. Even with dementia they might be able to tell you what they were doing or trying to do.
- Why did the resident fall? Ask any staff or potential witnesses.
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More actions to take post-fall:

Have someone take notes post-fall. We think we will remember all details, but we do not. Other people will see things differently or notice something you did not. Get information from all parties, so that you and your team can go back and try to find the root cause as to why the resident fell.
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Post-fall assessment considerations:

- **ALWAYS NUMBER 1**: Assess the resident!
- Assess the situation. What might have caused the fall? This is where it is handy to have others trained to utilize critical thinking to assess the area.
- Ask the resident questions as to what happened. Where were they going? What might have initiated the fall? Remember, even people with dementia can answer some questions (we just have to become investigators).
Monitoring post-fall:

- Never assume a resident’s complaint of pain or signs of injury are simply the minor effects of taking a tumble.
- Ensure all staff know that the resident fell AND keep them informed as to what the investigation uncovers. This is where communication between all departments and people is critical. Just knowing someone fell is not enough.
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Documentation:

- Recording specific information about each and every fall is an essential component of fall response and prevention.
- WHY? This will help ensure you have a plan for effective interventions. Without proper and accurate information people on the care team may start using subjective data: “Ms. Smith always falls there is nothing we can do, we are out of interventions.”
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Documentation (Continued):

- **WHY?** Regulatory and Litigation look closely at falls. Documentation may be your only evidence of appropriate response and follow-up. Do we have in our documentation the assessment, response, interventions and OUTCOME? Did we follow up to ensure the interventions we put in place are working?
- “The resident hasn’t fallen again, so it is working!” Right?
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Documentation (Continued):

- True quality improvement is based on data. That data comes from careful documentation and tracking of falls, interventions, and outcomes.

  P = Plan
  D = Do
  S = Study
  A = Act upon the study
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Components of a Successful Fall Prevention Program: Clinical Process of Care

- There is a system in place for identifying fall risk upon admission, after a fall, and with any change in condition and all staff must be continually trained and retrained on the system.

- A fall risk tool consists of identifying contributing diseases, drugs, cognitive factors, elimination or urinary factors, ambulatory aides, and mobility factors.
Components of a Successful Fall Prevention Program: Care Plan

- Involves implementation of targeted interventions (individualized per resident) aimed at reducing identified risk factors.
- Consists of multidisciplinary strategies targeted at identified risk factors.
- Includes a mechanism for communicating to ALL staff when an individual is deemed at-risk of a fall.

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Components of a Successful Fall Prevention Program: Post-fall Assessment

- Establish a formal post-fall process for investigating falls.
- Document circumstances of the fall (symptoms, location, activity, outcome), including any environmental hazards.
- Conduct a reassessment of the resident’s fall risk factors (root cause analysis).
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Components of a Successful Fall Prevention Program: Post-fall Monitoring

- Establish a process for monitoring risk or change of condition on a daily basis.
- Establish a follow-up process to determine whether the intervention(s) are reducing fall risk (not just to make sure they haven’t had another fall). In other words, is the intervention correct—*or have we just been lucky*?
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Organizational Components:

- Fall prevention policies, procedures, and guidelines for staff.
- A process for promoting a culture of safety throughout the facility.
- A process for evaluating the effectiveness of specific strategies and overall approaches to fall prevention.
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Organizational Components:

- Process for monitoring facility-wide fall and injury patterns and contributing factors, followed by implementation of appropriate preventions.
- System for recognizing and rewarding staff for their fall prevention efforts.
- Budget that supports the fall and injury prevention program.
If there is time: CASE STUDY 1

G.B. is a 76-year old nursing facility resident who has experienced several falls from bed. He has reported unsteadiness after getting up from bed. His medical problems include hypertension, treated with a diuretic. Medical evaluation revealed he was dehydrated and had orthostatic hypotension (dizziness rising from seated or lying position).

- With this information, what specific interventions would you include in his care plan in order to reduce fall risk?
- Based on the care plan which outcomes would you monitor this resident for?
Audience answers?
Case Study 2

A.C. is a 91-year old nursing home resident who has experienced several falls in the last few months (while transferring himself from his wheelchair). His falls occur as he attempts to transfer to his bed and/or the toilet. A few times he just slid out of his wheelchair and onto the floor. On one such occasion, the wheelchair tipped over and landed on top of him.

Medical history includes CVA with associated leg weakness and depression (for which he takes an antidepressant). He has stated he sometimes feels dizzy when transferring from his wheelchair.
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- Centers of Medicare and Medicaid
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- Evidenced-Based Falls Prevention- A Study Guide for nurses- Carole Eldridge, DNP,RN,CNAA-BC
- Preventing Patient Falls- Establishing a fall intervention program-second edition-Janice M, Morse, PhD (nursing), PhD (Anthro), FAAN
- Falls in Older People-Prevention & Management-fourth edition-Rein Tideiksaar- Ph.D.
QUESTIONS?
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Thank You and have a Wonderful Day!

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