Man Down! Creating a Successful Fall Prevention Program

MANHA 2024 ANNUAL CONVENTION

JUNE 2-5, 2024

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Objectives

- Review regulatory guidance and fall-related definitions
- Describe ways to proactively address fall prevention
- Identify suggestions for post-fall interventions
- Demonstrate integration of tools into a facility fall prevention program.

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Fall Facts and Stats

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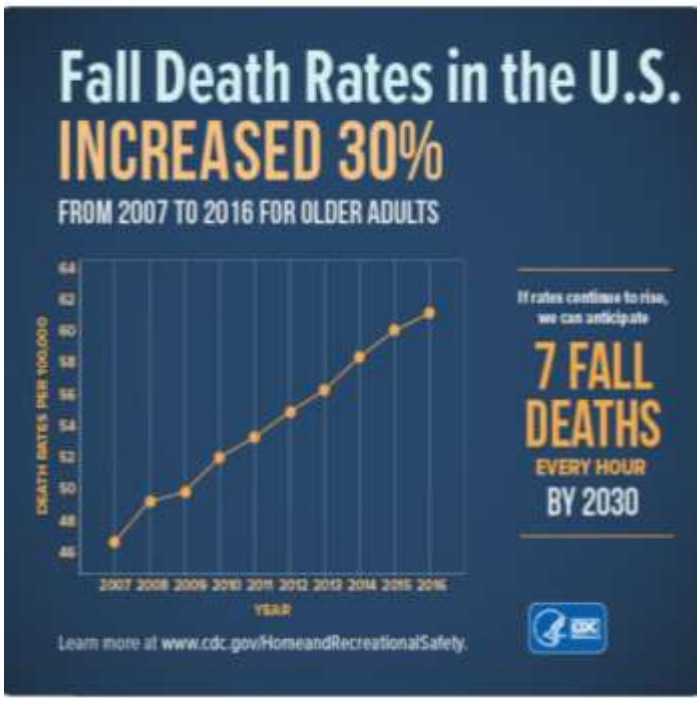

Facts About Falls

One out of 5 falls causes serious injury such as broken bones and head injuries

Each year 3 million older people are treated in the ED for fall injuries

Over 800,000 patients/year are hospitalized for a fall-related head injury or hip fracture

More than 95% of hip fractures are caused by falling, usually sideways

Falls are the most common cause of Traumatic Brain Injuries (TBI)

www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

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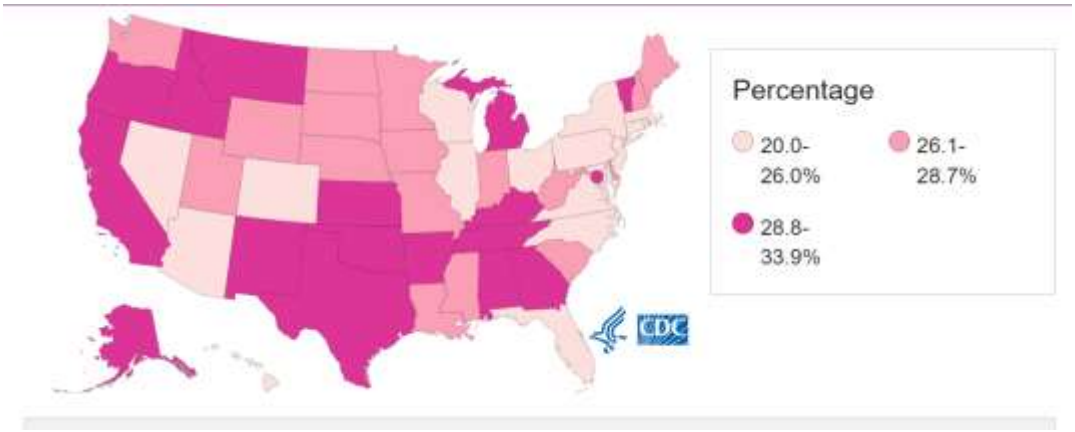
Falls Reported by State 2018



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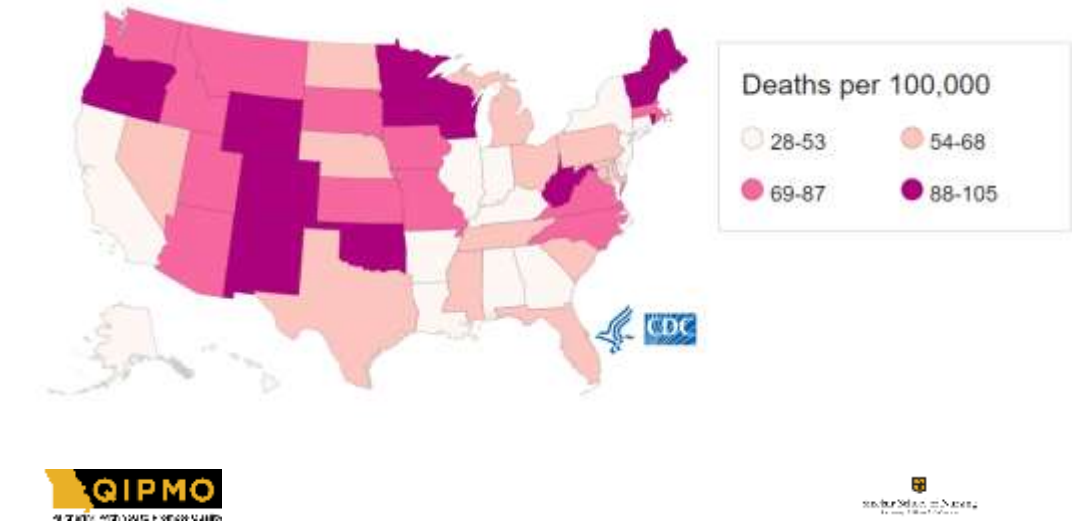
Deaths From Falls 2018



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Statistics

Muscle weakness and gait problems account for about 24% of nursing home falls and environmental hazards cause16% to 27% of falls for residents.

In older persons, age 65 or greater, falls are the leading cause of injury-related death, non-fatal injuries and hospital admissions for trauma.

Falls are associated with increased length of stay, increased healthcare utilization, poorer health outcomes and increased costs.

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QCOR FY 2023 Region 7 KC-MO

STANDARD

F0884	Reporting - National Health Safety Network	831
F0689	Free of Accident Hazards/Supervision/Devices	234
F0880	Infection Prevention & Control	223
F0812	Food Procurement, Store/Prepare/Serve Sanitary	203
F0658	Services Provided Meet Professional Standards	195
F0677	ADL Care Provided for Dependent Residents	169
F0600	Free from Abuse and Neglect	169
F0584	Safe/Clean/Comfortable/Homelike Environment	169
F0684	Quality of Care	129
F0656	Develop/Implement Comprehensive Care Plan	120

COMPLAINT

F0600	Free from Abuse and Neglect	152
F0689	Free of Accident Hazards/Supervision/Devices	114
F0658	Services Provided Meet Professional Standards	113
F0609	Reporting of Alleged Violations	94
F0684	Quality of Care	84
F0677	ADL Care Provided for Dependent Residents	75
F0610	Investigate/Prevent/Correct Alleged Violation	69
F0584	Safe/Clean/Comfortable/Homelike Environment	62
F0880	Infection Prevention & Control	54
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	50

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QCOR FY 2024 Region 7 KC-MO

STANDARD

F0884	Reporting - National Health Safety Network	316
F0812	Food Procurement, Store/Prepare/Serve Sanitary	189
F0880	Infection Prevention & Control	189
F0689	Free of Accident Hazards/Supervision/Devices	95
F0658	Services Provided Meet Professional Standards	83
F0677	ADL Care Provided for Dependent Residents	74
F0684	Safe/Clean/Comfortable/Homelike Environment	64
F0761	Label/Store Drugs and Biologicals	63
F0656	Develop/Implement Comprehensive Care Plan	48
F0550	Resident Rights/Exercise of Rights	46

COMPLAINT

F0689	Free of Accident Hazards/Supervision/Devices	39
F0658	Services Provided Meet Professional Standards	33
F0677	ADL Care Provided for Dependent Residents	22
F0609	Reporting of Alleged Violations	20
F0600	Free from Abuse and Neglect	18
F0610	Investigate/Prevent/Correct Alleged Violation	18
F0684	Quality of Care	18
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	16
F0880	Infection Prevention & Control	13
F0760	Residents are Free of Significant Med Errors	13

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Regulatory Description & Definitions

STATE OPERATIONS MANUAL (SOM)
RESIDENT ASSESSMENT INSTRUMENT(RAI) MANUAL

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F689 Free of Accident Hazards, Supervision/Devices

- §483.25(d) Accidents.
- The facility must ensure that –
- §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
- §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

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Intent

- INTENT: §483.25(d)
- 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. This includes:
  - Identifying hazard(s) and risk(s);
  - Evaluating and analyzing hazard(s) and risk(s);
  - Implementing interventions to reduce hazard(s) and risk(s); and
  - Monitoring for effectiveness and modifying interventions when necessary.

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FALL: SOM

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 where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, 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 (refer to Resident Assessment Instrument User's Manual. Version 3.0, Chapter 3, page J-31).

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FALL: RAI

FALL Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include **any** fall, no matter whether it occurred at **home**, while out in **the community**, in an **acute hospital** or a **nursing home**. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – **this is still considered a fall**.

CMS understands that challenging a resident's balance and training him/her to recover from a loss of balance is an **intentional therapeutic intervention** and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

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Avoidable Accident

- An accident occurred because the facility **failed** to:
  - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or
  - Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or
  - Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or
  - Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

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Unavoidable Accident

- An accident occurred despite sufficient and comprehensive facility systems designed and implemented to:
  - Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
  - Evaluate/analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible;
  - Implement interventions, including adequate supervision, consistent with the resident's needs, goals, care plan, and current professional standards of practice in order to eliminate or reduce the risk of an accident; and
  - Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.

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Supervision/Adequate Supervision

- An intervention and means of **mitigating the risk** of an accident. Facilities are obligated to provide adequate supervision to prevent accidents.
- Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment.
- Adequate supervision may vary from resident to resident and from time to time for the same resident.

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Assistance/Assistive Device

- Refers to any item (e.g., fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand- alone or overhead transfer lifts, canes, wheelchairs, and walkers, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety.
- NOTE: The currently accepted nomenclature refers to "assistive devices." Although the term "assistance devices" is used in the regulation, the Guidance provided in this document will refer to "assistive devices."

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Use of Mechanical Devices

- Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts, sit-to-stand devices, and transfer or gait belts
- The resident assessment helps to determine the resident's degree of mobility and physical impairment and the proper transfer method; for example, whether one or more caregivers or a mechanical device is needed for a safe transfer. Residents who become frightened during transfer in a mechanical lift may exhibit resistance movements that can result in avoidable accidents. Communicating with the resident and addressing the resident's fear may reduce the risk.

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Environment

- Refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.

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Risk

- Refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.

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Taking a Proactive Approach to Prevention

FACILITY COMMITMENT

RISK AND HAZARD IDENTIFICATION

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Committing to a Fall Prevention Program

- A Fall Prevention Program requires a top down/bottom-up approach from all stakeholders, (e.g. all staff, all departments, physicians, therapy, vendors, residents, families) and others associated with the organization
- Development of polices and procedures addressing the vision of the program, measurable goals and objectives, identification of resident risk, stakeholder roles and involvement, and communication methods for reporting progress toward goals.
- Identifying a champion to lead the program, e.g. DON/ADON, Restorative Coordinator, Staff Development Coordinator, QA Nurse or therapist
- Engage residents, families and care givers in identifying the resident's fall risk on admission as partners in the fall prevention program.

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A Culture of Safety

Acknowledge the high-risk nature of its population and setting	Develop effective communication, including a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;	Engage ALL staff, residents and families in training on safety, and promote ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families; (QAPI)
Encourage the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise; (How do you analyze data?- What data do you collect?)	Direct resources to address safety concerns; and	Demonstrate a commitment to safety at all levels of the organization.

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Evaluation and Analysis

- The process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents.
  - Interdisciplinary involvement is a critical component of this process.
- Analysis may include, for example,
  - considering the severity of hazards,
  - the immediacy of risk,
  - and trends such as time of day, location, etc.

- Both the facility-centered and resident-directed approaches include evaluating hazards and accident risk data which includes prior accidents/incidents, analysis to identify the root causes of each hazard and accident risk and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc.

EVALUATION

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Data Collection Tools for Risk and Hazard Identification

Facility Assessment Tool: high risk, high volume, problem prone	MDS: Sections B, C, D, E, GG, H, I, J, N, O and CAA triggers	Preadmission screening	Referral paperwork
Risk assessments: Fall, Braden, side rail, bowel & bladder, elopement	Medical history and physical exam	Resident observation and rounds	Environmental rounds
	Quality Measure reports, Facility and Resident Level summaries	QAA/QAPI activities	

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Pre-Admission Risk Identification and Interventions

Who does the talking?

- Social services: during the tour
  - What does family report?
  - Falls at home?
  - Medications?
  - Compliance?
  - Stubborn?
- DON:
  - Hospital admission paperwork
  - Medications?
  - Past procedures?
  - Diagnosis?
- Family:
  - Set up room prior to arrival
  - Familiar items: bedspread? Pillows? Pictures?
  - Similar set up to home
- Maintenance:
  - Routine maintenance
  - Checking of bed/wc brakes
  - Checking of additional equipment
- Rehab:
  - Education of new staff to proper lift use
- Laundry:
  - Checking lift slings/pads for wear as they come through for laundering

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Resident Risk Identification

- Consider unique characteristics and abilities for each resident:
  - Diagnosis: Fractures, Parkinson's disease, CVA, vertigo, hypotension, arthritis, osteoporosis
  - Physical abilities: Abnormal gait, balance issues, loss of limb(s), contractures
  - Cognition: Confusion, dementia, delirium, psychiatric/mood disorders
  - Strengths: Active engagement in care, desire to return home
  - Weaknesses: History of previous falls, impulsiveness, inability to follow simple directions, poor vision

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Contributing Factors

- Unsafe or absent footwear
- Underlying chronic medical conditions, such as arthritis, heart failure, anemia and neurological disorders
- Acute change in condition such as fever, infection, delirium
- Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.)
- Medication side effects
- Orthostatic hypotension
- Balance disorders
- Gait disorders
- Pain
- Visual deficits
- Lower extremity weakness
- Poor grip strength
- Cognitive impairment
- Incontinence

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FALL RISK EVALUATION

Perform a Fall Risk Evaluation upon admission/readmission, with each MDS assessment ,with a significant change in condition and after each fall.

Identify "at risk" residents, prioritizing based on:

Limited mobility and/or activity

Cognitive status (assess for delirium)

Medication review

Engage the resident, family and care givers as partners in the fall prevention program

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Potential Environmental Hazards and Risks

- Plant hazards:
  - Propped fire doors, disabled locks or latches
  - Nonfunctioning alarms: doors, personal
  - Buckled or torn carpet or flooring
  - Cords on floor: O2, electric beds, televisions, lamps, air mattresses, air pumps
  - Irregular walking surfaces/colored or patterned carpet, shiny floors
  - Ill fitting equipment: incorrect bed height and/or width, or improperly fitted or maintained wheelchairs, walkers
  - Poor lighting: too dim, too bright, glare

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Implementing Universal Fall Precautions and Post-Fall Interventions

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Implementing Universal Fall Precautions

Familiarize	Have	Keep	Have	Place	Keep	Keep
Familiarize the resident to the environment	Have the resident demonstrate call light use and keep the call light within reach	Keep the resident's personal possessions within safe reach	Have sturdy handrails in the resident's bathroom, room, and hallway	Place the bed in low position when the resident is resting in bed; raise the bed to a comfortable height when the resident is transferring out of bed	Keep the bed brakes locked	Keep wheelchair wheel locks in "locked" position when stationary, if appropriate

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Implementing Universal Fall Precautions

Keep	Use	Keep	Keep	Keep	Implement	Follow
Keep nonslip, comfortable, well-fitting footwear on the resident	Use night lights or supplemental lighting	Keep floor surfaces clean and dry. Clean up all spills promptly	Keep resident care areas uncluttered	Keep resident items within reach (nest)	Implement staff training on fall prevention, including use of lifts	Follow safe handling practices: • Complete scheduled rounding to ensure universal fall precautions are implemented, (bed in low position, mat on floor, wearing of non-skid socks) and resident needs are met

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Standardize and implement interventions based on patient risk for falling. Align individualized interventions to respective risk:

- Previous fall history
  - Determine circumstances of a previous fall
  - Implement tailored interventions to prevent a similar fall
- Gait instability/lower-limb weakness
  - Nonskid footwear
  - Assistive devices
  - Physical therapy
  - Assistance getting out of bed and with ambulation
  - Avoid bedrest
- Urinary incontinence, frequency, and/or the need for toileting
  - Hourly rounding
  - Toileting schedule
  - Incontinence briefs
- Agitation, confusion, impaired judgment
  - Frequent rounding/surveillance plan
  - Continuous virtual monitoring
  - Bed/chair alarm
  - Floor mats to reduce trauma from bed-related falls
  - Assess for alcohol/ drug withdrawal and place patient on appropriate protocol
  - Rule out delirium
- Medications, especially sedative hypnotics
  - Consult pharmacist about medications
  - Assess for/treat orthostatic hypotension (adequate fluid intake, slow position changes, compression stockings)
- Advanced age
- Poor vision and/or difficulty hearing

IMPLEMENTATION STRATEGIES

Incorporate alerts, tasks, records, prompts in the EHR

Initiate walking rounds that include fall risk concerns

Optimize resident mobility:

Address potential impact of immobility: loss of muscle mass and strength, loss of independence, potential for chronic pain, potential loss of confidence after a fall

Address "fear" of falling

Recognize limitations of select interventions: bed alarms, sitters, signage

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Post-Fall Actions

- Ascertain if there were injuries, and provide treatment as necessary
- Determine what may have caused or contributed to the fall (root cause analysis), including ascertaining what the resident was trying to do before he/she fell
- Conduct a post-fall huddle as soon possible after the fall
- Involve all staff levels, and the resident, if possible
- Discuss the fall, how it happened and why, addressing any psychological factors (medications or medical conditions)

Ensure the huddle includes:

- Whether appropriate interventions were in place
- Special considerations as to why the fall may have occurred:
  - Call light on? How long?
  - Staffing at the time of the fall
  - Environmental care factors in play, (e.g., toilet height, slip/trip hazards, lighting)
  - How similar outcomes may be avoided
  - How the care plan has changed: revise with interventions and/or referrals

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Root Cause Analysis

Problem statement	One sentence description of event or problem Mr. Jones was found on the floor
Why?	He attempted to self transfer
Why?	He needed to go to the bathroom
Why?	He received his am Lasix
Why?	His call light wasn't answered
Why?	Staff assisting other residents
Root Cause(s)	1. 2. 3. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

- Statement: *The resident fell*

  Ask the question WHY, repeating 5 times to get to the "root cause" of the fall
- Determine what may have caused or contributed to the fall (root cause analysis), including ascertaining what the resident was trying to do before he/she fell
- Discuss the fall, how it happened and why, addressing any psychological factors (medications or medical conditions)

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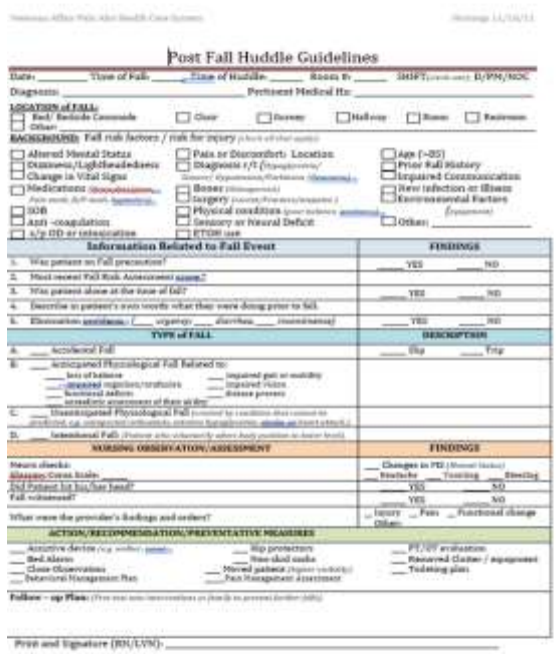

Post Fall Huddle Guidelines

Date: ______ Time of Fall: ______ Time of Huddle: ______ Room #: ______

Diagnosis: ______ Pertinent Medical Hx: ______

LOCATION of FALL:

BACKGROUND: Fall risk factors / risk for injury

Information Related to Fall Event	FINDINGS
1. Was patient on Fall precaution?	___ YES ___ NO
2. Most recent Fall Risk Assessment score?	
3. Was patient alone at the time of fall?	___ YES ___ NO
4. Describe in patient's own words what they were doing prior to fall.	
5. Elimination	___ YES ___ NO
TYPE of FALL	**DESCRIPTION**
A. ___ Accidental Fall	___ Slip ___ Trip
B. ___ Anticipated Physiological Fall Related to:	
C. ___ Unanticipated Physiological Fall	
D. ___ Intentional Fall	
NURSING OBSERVATION/ASSESSMENT	**FINDINGS**
Neuro checks:	
Did Patient hit his/her head?	___ YES ___ NO
Fall witnessed?	___ YES ___ NO
What were the provider's findings and orders?	
ACTION/RECOMMENDATION/PREVENTATIVE MEASURES	

Follow-up Plan:

Print and Signature (RN/LVN):

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Resident Interventions

- Therapy: PT/OT/ST/Restorative
- Social services, psychologist/psychiatrist
- TOILET, TOILET, TOILET!
- Hydration
- Feet:
  - Footwear, non-slip socks
  - Check no slip surfaces
  - Shuffling gate
  - Cognitive impairment? Moccasins or non-slip socks
- Pain
- Glasses: are they clean? Contacts?
- Belongings in reach (nest)
- Orthostatic issues
- Anticipate needs
- Avoid sensory overload
- Environment changes
- Rest periods
- Activities
- Exercise
- Exercise pedals
- Distractions while waiting
- Wii
- Dance music therapy
- Daily ambulation program (group/individual)
- Hip protectors, knee/elbow pads
- Cues/reminder signs
- Large number clocks/calendars
- Reminiscence/life review
- Tapes of loved ones and friends (family videos or albums)
- Spiritual support
- Intergenerational cultural, pet programs
- Remove objects that may trigger (i.e. coat hat, suitcase)
- Limit caffeine
- HONOR THEIR ROUTINE
- Involve in choices and plan
- Safety contract

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Family Interventions

- Education: if the resident fell at home… behavior likely to continue when in our care
- Involve in planning care
  - Predicted course of illness
  - Anticipated behavior/cognitive changes
- Patient history: habits and customs
- Coping mechanisms/triggers (dates, smells, color, person)
- Encourage use of family/sitters to stay with high-risk resident (essential caregivers)
- Recording of reassuring messages (this may agitate some residents and cause them to look for the family member)
- Family scrap book or photo box, memorable event/objects of affection

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Environmental Interventions

- Personalize rooms, familiar objects
- Room relocation
- Call light system
- Bedside commode
- Bed height
- Trapeze, bed handle, transfer pole
- Body pillows
- Bolsters
- Bedside table
- Clutter free
- Frequent rest areas
- Position bed to accommodate weakness
- Reduce noise
- Floor mats
- Padding
- Carpeted surfaces or non-slip wax, low buff to reduce glare
- Non-skid on floor in front of sink, toilet, bed
- Exit doors (keep exit door closed, stop signs)
- Higher seated lounge chairs and toilets
- Appropriate size equipment
- Visual cues/signage
- Memory trigger
- Minimized hall equipment
- Adequate lighting
- Light and color, high contrast/avoid busy patterns
- Property fencing
- Establish a wandering path/ courtyard

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Staff Interventions

- Everyone is responsible!!!!!
- Fall prevention team includes direct care staff
- House rules:
  - Clean up spills immediately
  - Pick up/move items
  - Identify rough flooring/carpet
  - Report light not working
  - Clean dirty eyeglasses
  - Address pants too long
- Determine reason for and relieve discomfort
- Frequent rounding with eyes open
- Address call light promptly
- Permission before touching, moving, hugging
- Move slowly around ambulatory residents/avoid abrupt changes or rushing
- Calm approach
- Avoid confrontation
- Consistent caregivers
- Actively listening/validate feelings
- Structured activities
- Assess sleep pattern
- Assistive devices in use, properly used
- Medication review/changes

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Supervision

- Supervision is an intervention and a means of **mitigating accident r**isk. Facilities are obligated to provide adequate supervision to prevent accidents.
- Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.
- Devices such as position change alarms may help to monitor a resident's movement temporarily, but do not eliminate the need for adequate supervision.
- The resident environment may contain temporary hazards (e.g., construction, painting, housekeeping activities, etc.) that warrant additional supervision or alternative measures such as barriers to prevent access to affected areas of the resident environment.
- Adequate supervision to prevent accidents is enhanced when the facility:
  - Accurately assesses a resident and/or the resident environment to determine whether supervision to avoid an accident is necessary; and/or
  - Determines that supervision of the resident was necessary and provides supervision based on the individual resident's assessed needs and the risks identified in the environment.

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Implementation of Interventions

Implementation refers to using specific interventions to try to reduce a resident's risks from hazards in the environment

The process includes:

- Communicating the interventions to all relevant staff
- Assigning responsibility
- Providing education, as needed
- Documenting interventions (e.g. care plans for the individual resident or plans of action developed by the Quality Assurance Committee)
- Ensuring interventions are put into action and monitored

Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with professional standards, including evidence-based practice.

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Implementation of Interventions

Development of interim safety measures may be necessary if interventions may not immediately be fully implemented

Facility-based interventions may include, but are not limited to:

- Educating staff
- Repairing a device/equipment
- Developing or revising policies and procedures

Resident-directed approaches may include implementing specific interventions as part of the plan of care, supervising staff and residents, etc.

Documentation in facility records and the resident's care plan should include the newly implemented interventions

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Monitoring and Modification

Monitoring is the process of evaluating the effectiveness of care plan interventions

Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks

Monitoring and modification processes include:

- Ensuring that interventions are implemented correctly and consistently
- Evaluating the effectiveness of interventions
- Modifying or replacing interventions as needed
- Evaluating the effectiveness of new interventions

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Care Planning

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The 5 P's of Fall Prevention

Pain—is your resident experiencing pain?

Personal needs—does your resident need assistance with personal care?

Position—is your resident in a comfortable position?

Placement—are all your resident's essential items within reach?

Prevent falls—always provide person-centered care

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Care Plan Example

- Traditional

  Problem: Resident has a hx of falling d/t/weakness and unsteady gate

  Goal: Resident will remain free from falls for the next 90 days

- Person-Centered

Jim has a history of falling late in the afternoon. He walks all throughout the day with his walker. Jim has early stages of dementia and gets restless. Walking helps him relieve anxiety; however, by the end of the day he is tired.

Staff will be available to walk with Jim and engage him, particularly as he tires, using poetry gait rhythm method that encourages rest stops. Jim's goal will be to reduce the number of episodes and risk of injury from falling while improving his quality of life through meaningful engagement.

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Care Plan Example

- Bill has experienced impaired physical mobility due to ongoing weakness to his right lower extremity caused by a CVA in 2019. He currently utilizes a walker but has a goal of advancing to a quad cane. He was recently hospitalized for pneumonia which has led to an overall weakened state putting him at risk for falls. Bill is admitted to Mary Hall for short term rehab.

- Bill's goal during his short stay is to improve his stamina to his prior level of function or better while reducing the potential risk of falling. Staff will encourage Bill to request assistance as needed with transfers and ambulation while working with therapy. He will continue to ambulate utilizing his walker. His current medication regimen includes Losartan/HCTZ daily. Bill will notify staff if he experiences dizziness or lightheadedness. Staff will monitor Bill's vital signs and report any abnormalities to his PCP.

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Care Plan Example

- Mr. Daniels has dementia, is unsteady on his feet and has fallen three times in the past month. He has a limited ability to communicate his needs to staff. He currently receives Aricept 10mg daily.
- The goal for Mr. Daniel is to reduce the likelihood of falls while maintaining his dignity and independence through the next review.

- Staff have tried several interventions, but he continues to fall. Staff are unable to determine why he is falling.

Possible interventions:

- Monitor for potential medication side effect, i.e. lightheadedness, nausea, vomiting, diarrhea. Los of appetite, insomnia or tiredness
- Look for patterns in the time of day, location of the falls and possible activity resident was attempting (toileting need, self transfer, looking for his room)
- Communicate with the family, inquiring about past routines, occupation and hobbies
  - After talking with the family, staff learned that Mr. Daniels had a grandparent who fell out of a recliner. A week ago, staff moved a recliner into Mr. Daniel's room and that is when he began falling. Any time someone tried to sit in the recliner, Mr. Daniels became anxious. Without family input, staff would not be aware of the recliner incident.

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Tools for a Successful Fall Prevention Program

- FACILITY ASSESSMENT
- IDT POST-FALL ASSESSMENT
- INTERACT FALL CARE PATH & STOP AND WATCH TOOL
- NEUROLOGICAL FLOWSHEET
- CMS CRITICAL ELEMENT PATHWAYS
- HSAG QM TIP SHEETS

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Facility Assessment: Care & Competencies

Staff competencies and annual training requirements per regulatory authority and/or facility policy:

- Abuse, Neglect, Exploitation, and Misappropriation
- Advance Directives
- Behavioral Health
- Communication
- Compliance and Ethics
- CPR
- Dementia Care Management
- Equipment and assistive device training
- Infection Control
- Other areas identified as areas of weakness during annual performance review/competency evaluation
- Promoting resident's independence
- Quality Assurance and Performance Improvement
- Resident Rights including confidentiality of resident information, right to dignity, privacy, and property
- Safety and emergency procedures, including the Heimlich Maneuver
- Job responsibilities and lines of authority
- Emergency Preparedness
- Facility policies and procedures

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IDT Post-Fall Assessment sample

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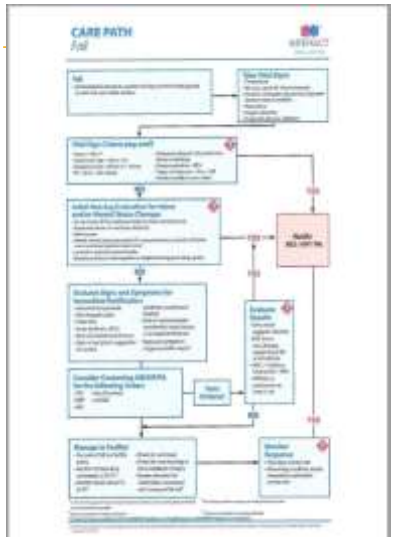
Interact Tools



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Neurological Flow Sheet


NEUROLOGICAL ASSESSMENT FLOW SHEET

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Accidents Critical Element Pathway

Use this pathway for a resident who requires supervision and/or assistive devices to prevent accidents and to ensure the environment is free from accident hazards as is possible.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C, E, GG, H, J, N, O, and P.
- ☐ Physician's orders.
- ☐ Progress notes related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ If available, investigation report related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ Pertinent diagnoses.
- ☐ Care plan interventions for the following:
  - Smoking/Use of Electronic Cigarettes;
  - Resident-to-Resident Altercations (also being reviewed under the Abuse pathway);
  - Falls;
  - Wandering and elopement, and/or
  - Safety/Entrapment (e.g., physical restraints, bed rails).

Observations for all areas:

- ☐ What type of supervision is provided to the resident and by whom?
- ☐ How are care-planned interventions implemented?

Wandering and Elopement Observations:

- ☐ Where is wandering behavior observed?
- ☐ What interventions are implemented to ensure the resident's safety?
- ☐ If the resident is exit seeking, what interventions are implemented to prevent elopements?

Smoking/Use of Electronic Cigarette Observations:

- ☐ Is the resident smoking safely (observe as soon as possible):
  - Is the resident supervised if required;
  - Does the resident have oxygen on while smoking;
  - Does the resident have a smoking apron or other safety equipment if needed;
  - Does the resident have difficulty holding or lighting a cigarette,
  - Are there burned areas in the resident's clothing/body; and
  - Does the resident keep his/her cigarettes and lighter?
- ☐ Is the resident using an electronic cigarette in his or her room or in a non-smoking area?
  - Do other residents appear to be bothered by the electronic cigarette use?

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CMS 20017 Accidents CEP

FALL OBSERVATIONS

Fall Observations:

- ☐ How does staff respond to the resident's requests for assistance (e.g., toileting)?
- ☐ What effective interventions are implemented to prevent falls? Examples may include:
  - Responding to the resident's requests timely;
  - Placing the resident in a low bed, or providing a fall mat;
  - Monitoring resident positioning to prevent sliding/falling;
  - Providing proper footwear to prevent slipping;
  - Providing PT/OT/restorative care; and/or
  - Assuring the resident's room is free from accident hazards (e.g., providing adequate lighting, assuring there are no trip hazards, providing assistive devices).
- ☐ Does the resident have a position change alarm in place:
  - What evidence is there that this device has been effective in preventing falls;
  - Is there evidence this device has had the effect of inhibiting or restricting the resident from free movement out of fear of the alarm going off (See Physical Restraints); and
  - Is there evidence that the alarm is used to replace staff supervision?

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RESIDENT/RP INTERVIEWS THERAPY INTERVIEWS

Falls:

- ☐ Have you fallen in the facility? If so, what happened? Were you injured from the fall?
- ☐ What were you trying to do when you fell?
- ☐ What has staff talked to you about regarding how to prevent future falls?
- ☐ What interventions have been put in place to help prevent future falls? Are they working? If not, why?

Therapy and/or Restorative Manager Interviews (for falls, restraints):

- ☐ What therapy/restorative interventions were in place before the accident occurred?
- ☐ What therapy/restorative interventions were implemented following each accident?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident or resident representative in decisions regarding interventions? If so, how?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ What did you do if the resident fell while going to the restroom?
- ☐ Ask about concerns based on your investigation.

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Accidents CEP

Record Review:

- ☐ Review nursing notes, therapy notes, and IDT notes. Has the resident's accident risk been assessed (e.g., fall risk, elopement risk, or safe smoking assessment)?
- ☐ Were the underlying risk factors identified?
- ☐ Has the resident had any accidents since admission?
- ☐ Were preventative measures documented prior to an accident:
  - Was the accident a result of an order not being followed? A care intervention not being addressed? A care-planned intervention not implemented?
- ☐ For a resident-to-resident altercation, were interventions reviewed and revised based on the resident's response(s) and evaluated for effectiveness? If not effective, what alternative interventions were implemented?
- ☐ Were the circumstances surrounding an accident thoroughly investigated to determine causal factors:
  - Were the cause and any pattern identified (e.g., falls that occur at night trying to go to/from the bathroom); and
  - Was the resident's accident risk addressed appropriately?
- ☐ Review laboratory results pertinent to accidents.
- ☐ Has the care plan been reviewed and revised if indicated to reflect any changes as a result of an accident(s)?
- ☐ Are injuries related to the accident assessed and treatment measures documented?
- ☐ Are changes in the resident's accident risk correctly identified and communicated with staff and practitioner?
- ☐ Based on a review of the most recent MDS Assessment (J1900), if the resident had a fall(s), is the MDS coded accurately for falls in each category (no injury, injury except major, major injury)?
- ☐ If concerns are identified, review facility policies and procedures with regard to accidents, and relevant policies related to the concern identified.

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Additional CEPs to Consider

- **20080** Specialized Rehabilitative or Restorative Services CEP: Use this pathway for a resident to ensure the facility obtains and provides necessary rehabilitative or restorative services. It includes the use of assistive devices. Surveyor to review to ensure resident receives necessary rehab or restorative services
- **20066** Activities of Daily Living (ADL) CEP: Use this pathway for a resident who requires assistance with or is unable to perform ADLs. Care plan (e.g., ADL assistance, specific care interventions staff will provide, premedication prior to ADLs, environmental approaches and devices used to maximize independence, therapy interventions, or restorative approach).
- **20120** Positioning, Mobility and Range of Motion (ROM) CEP: Use this pathway for a resident with concerns related to ROM, mobility, and/or positioning.
- **20125** Bowel and Bladder Incontinence CEP: Use this pathway for a resident identified with concerns related to bladder or bowel incontinence. Whether environmental accommodations have been made to promote continence, such as providing adaptive equipment or devices, based on resident identified needs, such as elevated toilet seats, grab bars, urinals, bedpans, or commodes; and assuring adequate lighting and assistance as needed to use devices such as urinals, bedpans and commodes.

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Quality Measure Tip Sheet:
Falls With Major Injury—Long Stay

Quality Measure Overview

MDS Coding Requirements

Ask These Questions...

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FALLS WITH MAJOR INJURY

Was a Fall Risk assessment completed to identify risk?

Was a process in place to initiate prevention measures?

Were prevention measures communicated to staff?

Are gait belts accessible for transfers?

Are direct care staff proficient in transfers and mobility functions?

Are vision issues addressed?

Is appropriate footwear used?

Quality Measure Tip Sheet: Activities of Daily Living—Long Stay

★★★★★ This measure is used in the 5-star quality rating system

Quality Measure Overview

- This measure reports the percentage of residents whose need for help with late-loss activities of daily living (ADLs) has increased when compared to the prior assessment.
- Long-stay residents with selected target and prior assessment assessments that indicate the need for help with late-loss ADLs has increased when the selected assessments are compared.
  - An increase is defined as an increase in two or more coding points in one late-loss ADL item or one point increase in coding points in two or more late-loss ADL items. Note that for each of these four ADL items, if the value is equal to [7,8] on either the target or prior assessment, then recode the item to equal [6] to allow appropriate comparison.
- **This measure involves four late-loss ADLs:**
  - Bed mobility
  - Eating
  - Transferring
  - Toileting

Exclusions:

- All four late-loss ADL items indicate total dependence on the prior assessment (4, 7, 8 coded).
- Three of the late-loss ADLs indicate total dependence on the prior assessment, and the fourth late-loss ADL indicates extensive assistance.
- Resident is comatose.
- Prognosis of life expectancy is less than six months.
- Hospice care is employed.
- Resident is not in the numerator and bed mobility or transferring, eating, or toileting equal [-].

MDS Coding Requirements

Refer to Section G

In the Minimum Data Set (MDS):

- Include look-back period of seven days.
- Code based on resident's level of assistance when using adaptive devices such as a walker, a device to assist with donning socks, a dressing stick, a reacher, or adaptive eating utensils.
- Capture the total picture of the resident's ADL performance 24 hours a day for the entire seven-day period.
- Indicate if the activity occurred three or more times within the seven-day period, using the ADL Self-Performance Algorithm (see the Resident Assessment Instrument [RAI], page G-8).

Consider These Questions ...

- Was the MDS coded per RAI requirements?
- Is the staff member's coding documentation accurate?
- Is the MDS designee completing self-observation of care and staff member interviews to determine accuracy of documentation?
- Has baseline function been determined?
- Has the root cause for the decline been determined and treated?
- Has the resident been referred to therapy for treatment?
- Are underlying health conditions that may be affecting ADL performance being treated?
- Is pain/depression managed?
- Is the resident receiving appropriate assistance from staff members?

ADLS

Has a baseline function been determined?

Has the root cause for the decline been determined and treated?

Has the resident been referred to therapy for treatment?

Have restorative programs been initiated to rehabilitate or maintain the resident's ADL performance?

Does evidence exist of the delivery of services for residents on a restorative program?

Is the resident receiving appropriate assistance from staff members?

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Fall Interventions

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Resources

- www.cms.gov State Operations Manual Appendix PP, Critical Element Pathways 20127, RAI User Manual Version 3.0
- www.hsag.com HSAG Field Guide: Falls QM Tip Sheets
- www.briggshealthcare.com Fall Risk Evaluation CFS6-17P 9/2020, Interdisciplinary Post-Fall Assessment 1161P, Neurological Assessment Flow Sheet CFS6-19HF
- https://pathway-interact.com Fall Care Path, Stop and Watch
- https://qcor.cms.gov
- www.nursignhomehelp.org Post Fall Huddle
- https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man2.html The Falls Management Program
- Falls: From Preadmission to Discharge: Melody Schrock RN, BSN, RAC-CT QIPMO Clinical Educator
- ER visits linked to falls spike among California Seniors. Kaiser health News. February 21, 2017

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Debbie Pool, BSN, RN, LNHA, QCP, IP
QIPMO Clinical Educator/Consultant
MU Sinclair School of Nursing
poold@missouri.edu

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