ENSIGN SERVICES

POSTette: Fall Reduction Part 2: Strategies Post Fall

References: State Practice Acts; MAC LCD's; CMS; APTA, AOTA, ASHA

If people didn't move, they wouldn't fall. They often fall because they "want something" (i.e. they have an unmet need; they are motivated to move, etc.)

The following are suggestions for best practices of managing a patient post fall.

IDT Considerations if a Fall Occurs:

- Complete a head to toe assessment looking for injuries or any possible contributing factors to the fall
- Complete orthostatic blood pressure checks and check blood sugar
- Check vital signs for elevated pulses and respirations as these may be a sign of a cardiac issues or a systemic concern
- Inform the physician of the assessment findings.

Once a fall is reported in an IDT meeting, the interdisciplinary team should consider going to the location where the fall occurred and "huddle" with the nurses, resident & CNAs to discuss the fall.

- Talk to the resident and the team on the unit.
- Take time to listen to the Patients summary of how and why the fall occurred. Consider asking them "re-enact" a transfer etc., to determine weakness or areas to target for intervention.
- Take time to listen to the CNA, Nurses summary of what happened. What are the patient's normal behaviors – when the fall occurred was something different than normal? Ask:
    - Why do you think he fell?
    - Is this unusual for him?
    - What do you do to keep him from falling when you care for him?
    - What can we do right now so he doesn't fall the rest of our shift
    - Ask "Why" 5 times

Considerations to assess:

- What is in place now?
- What did the resident report?
- Is the resident worried about anything (family, money, place to stay, etc.)?
- Is it a change in condition? Medical workup, labs, x-rays, med changes, etc.
- What did the patient want before they fell?
- When was the patient last medicated for pain or offered Tylenol?
- Is the patient motivated to move? Restless, anxious, bored, etc.?
- Is there an underlying unmet need?

Sleep Hygiene Questions:

- What time did he/she go to bed? To Sleep?
- Is the room too hot or too cold?
- Were they thirsty/ hungry?
- Was it too noisy?
- Are there too many/not enough lights?

Toileting Questions:

- Were they attempting to get to the bathroom?
- Is the patient incontinent?
- When was he/she last toileted?
- Is he/she on a diuretic?
- Can he use a urinal?

Assess the environment, any noticeable concerns with:

- Clutter in room/bathroom
- Tubing on the floor
- Phone cords
- Furniture/Equipment Placement
- Bathroom accessibility
- Wet floor
- Poor lighting
- Placement of grab bars or hand rails
- Appropriate bed height
- Temperature
- Was the appropriate equipment in the room or available?
- W/C auto locks; anti tippers in working order?
- Location of assistive devices

Additional Rehab questions to ask the Clinical Team when doing fall screens	
Positioning	• Does the patient have difficulty maintaining good positioning in bed and/or in the w/c? • Does the patient require frequent re-positioning? Or makes attempts to reposition themselves? • Were all/any care planned safety and/or positioning devices in place (and correctly applied) at the time of the fall?
Pain	• Had the patient been reporting /being treated for pain prior to fall?
Cognition/ Communication	• Can the patient use the call light? • Can the patient express their needs? • Can the patient follow directions?

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Additional Rehab questions to ask the Clinical Team when doing fall screens	
Strength/ Balance/ Mobility	• Are there any safety concerns regarding the patient's ability to use mobility devices? • Has the patient exhibited any signs of weakness or complaints of "legs giving out" prior to or at the time of the fall? • Has the patient reported being dizzy? • Does the patient appear motivated to move in order to accomplish a specific task? I.e. reaching for something, trying to find someone, etc.?

Develop a plan

- If the patient is currently on rehab services, make sure the fall and any plan to modify treatment is addressed in the documentation. Recommend this is done within 72 hours of the reported fall.
- If the patient is not on caseload, use the information as a screen to consider what rehab services can add to patient success.
- Add strategies/interventions to the Resident Care Plan.

Post-Fall Interventions to Consider:

Research shows, there is a greater reduction in falls if more than one intervention is in place

- Removal of Unnecessary Medications (consult with pharmacist and physician)
- Rehab Intervention (positioning, modification of environment, strength, ambulation, agility, balance, transfer, cognition, footwear, etc.)
- Correct Sensory Impairments
- Environmental modifications and safety assessments
- Alleviate Boredom (find out their preferred hobbies and activities, involve family)
- Toileting Program
- Assess Bathroom set up (grab bars, non-skid strips, seat height, arm rests for sit to stand success, lighting, color contrast)
- W/C positioning / cushions
- Mattress borders
- Sensory lighting
- Set up room to accommodate what a patient needs (remote near-by, location/height of bed, objects in path to bathroom, etc.)
- Visual enhancers on grab bars, call lights, assistive devices, etc.
- Assist patients to change positions, get up or lay down if "slumping" etc.
- New admits: assess vitals including orthostatic BP's for signs
- Blood sugar checks after patient falls and random as follow up assessment
- Assess footwear

What about Alarms?

When able always try something besides alarms… consider the following:

- Alarms are only 50/50 and/or happenstance (are they connected right, batteries checked, patient can disconnect, etc.)
- Alarms have the best of intentions, to alert staff when a patient is attempting to move, however often staff can't get to the patient soon enough, despite their efforts.
- Alarms agitate everyone, especially the person whom it is connected to
- So now you might have a patient who has fallen and is quite possibly agitated and afraid

Did you know tag F-252 States……

- The widespread and long-term use of audible chair and bed alarms has increased in facilities.
- Alarms should have a limited use (if at all) for diagnostic purposes or according to their care planned needs.
- These devices can startle and constrain the resident from normal repositioning movements, which can be problematic.

The most successful fall reduction programs involve the entire team. Good communication and working together will attain the best outcomes.