Long-Term Care Survey Alert

Fall Prevention - Park Your Misconceptions: You Can Manage Fall Risk In Residents With Parkinson's Disease

5 strategies to help residents with this common neuro condition keep moving without getting hurt.

If you simply accept a resident with Parkinson's disease as a fall waiting to happen, your survey will be an F tag waiting to be written.

That's the key message of experts who say there's plenty nursing facilities can -- and should -- do to help prevent falls and fall-related injuries in this vulnerable population.

These five strategies can help keep people with Parkinson's disease on their feet, and your facility from ending up with immediate jeopardy for failing to prevent one fall too many.

1. Do a careful observation of all residents to identify those with undetected Parkinson's disease or Parkinsonism and its potential impact on their mobility status and fall risk. "You don't need to do tests for PD -- just watch the person walk," suggested **Joseph Friedman, MD**, chief of neurology at **The Memorial Hospital of Rhode Island** in Pawtucket, in comments at the June 2004 **National Association of Directors of Nursing Administration in Long Term Care** conference in Orlando. The resident with PD may shuffle, keep his head down, tilt backwards or forwards and fail to swing his arms when he walks. (Note: Other conditions can mimic PD, so the resident with such symptoms should have a careful evaluation by the attending physician and/or neurologist.)

2. Assess for the impact of antipsy-chotic and other medications on Parkinson's disease or as a cause of Parkinson's type symptoms. "If a resident starts falling after he starts on an antipsychotic medication, assess him for undiagnosed Parkinson's (gait disturbance, akathisia) that's worsened by the medication," suggested **Lori Daiello, PharmD, BCPP**, with **Pharmacotherapy Solutions** in Orlando, during a NADONA presentation.

Remember: Antipsychotic and other medications can also cause extrapyramidal symptoms that make residents more likely to fall, Friedman warned. "People with Parkinson's disease are most sensitive to antipsychotic drug-induced movement disorders," he cautioned. (Wondering if the resident really needs an antipsychotic med? Take the assessment test.)

Tale from the trenches: Other drugs can cause a person with PD to go downhill -- fast. For example, one resident with PD became increasingly stiff and quit doing her activities of daily living within a month after admission to a nursing facility. The woman's daughter insisted that the facility had to be doing something to cause her mother's rapid decline.

It turned out the daughter was right: The physician had prescribed metoclopramide (Reglan) to treat the resident's longstanding complaint of nausea (which worked) but the drug had also caused the resident's PD to accelerate with frightening speed. "The facility reversed the woman's deteriorating condition by stopping Reglan," Friedman related.

Lesson learned: Recognize that common anti-nausea meds, such as Reglan or Compazine, aren't benign drugs for people with PD.

3. If an antipsychotic drug is required to manage serious behavioral symptoms or psychosis, ask the physician to use one of the atypical antipsychotics with low or no incidence of motor side effects.

Quetiapine (Seroquel) has been shown not to cause or exacerbate movement disorders, according to Friedman. In that regard, "clozapine is actually the best antipsychotic drug for patients with PD, but it requires weekly monitoring of blood

counts, so we almost never prescribe it as the first drug," he tells **Eli**.

4. Work closely with a neurologist to find the best anti-Parkinson's medication regimen for a particular resident to promote his optimal functioning. Anti-Parkinsons drugs like Sinemet metabolize very quickly, so frequent dosing is sometimes needed to keep the person mobile through the main part of the day, according to **Karen Clay, RN, BSN, CWCN**, a consultant in Brimfield, MA. "And you'll see dramatic differences with many residents when the drug is 'out of the system'where they quickly recoup after having their meds," she adds.

Tip: Do care-planned rest periods during times you know the resident will be less functional or at higher risk of falls, Clay suggests. Medication regimens for people with PD are very individualized with a goal toward promoting optimal functioning and mobility, agrees Friedman.

Assessment gem: Maintain a log of the resident's mobility and functional status to show fluctuations in the resident's daily functioning, he suggests. "The neurologist will want to know how good it gets for the resident -- and when he's off, how off he is," Friedman offers. "Without such assessment, the resident shows up at the neurologist with a note from the facility saying that the resident has major fluctuations; yet, the resident (if cognitively impaired) can't really specify what's going on," Friedman cautions.

5. Devise specific therapy and restorative nursing interventions to help residents with PD to diminish their fall risk. "You want to teach people with PD how to walk properly so they don't fall -- and how to use the right walker or a cane correctly, if they need it," says **Bob Kann, PT**, rehab director at **Laurels of Shane Hill**, a skilled nursing and rehab facility in Rockford, OH. (For specific therapy and restorative nursing tips for people with PD, see "Care Planning".)