Long-Term Care Survey Alert

Quality of Care: Apply This 4 Step Approach to Reduce Falls Risk, Upgrade Resident Care

Implement the updated Clinical Practice Guideline for Falls for improved results.

Resident falls in nursing facilities often appear to be an inevitable fact of life, but your facility can make great strides in preventing falls and serious resident injuries by implementing the updated Clinical Practice Guideline for Falls, advises **Barbara Resnick, PhD, ANP**, professor at the **Maryland School of Nursing**, and subcommittee chair for the 2011 revision of the Falls CPG.

No simple solutions: "I wish that I could tell you that I had the perfect solution . . . but preventing falls in the long-term care setting is challenging," Resnick said at the "Update on the Clinical Practice Guideline for Falls in the Long Term Care Setting" session at the AMDA annual conference earlier this year. Because many nursing home residents have cognitive problems, chronic medical conditions, and physical limitations, they are more likely to fall, and more likely to endure injuries after a fall, than those living in the community, she notes.

The CPG for falls in the long-term care setting uses a four-step approach:

Step 1. Recognition -- identifying the presence of a risk or condition.

Step 2. Assessment -- clarifying the nature and causes of a condition or situation and identifying its impact on the individual.

Step 3. Treatment -- selecting and providing appropriate interventions for that individual.

Step 4. Monitoring -- reviewing the course of a condition or situation as a basis for deciding to continue, change, or discontinue interventions.

Risky residents: Step 1 should be fairly easy for long-term care providers because virtually every resident is at risk for falls, Resnick says. "It is more helpful to focus on specific risk factors," she advises. Step 2 then expands on the resident's individual risk factors for falls. "This might include such things as comorbidities, fear of falling, deconditioning, medications that have central nervous system effects, or vitamin D deficiency," she says. Screening and assessment are most effective if the following are included:

- A focused history including prior falls, medications, and medical problems.
- A physical exam that includes gait and balance, mobility, a neurological exam, a musculoskeletal exam, cardiovascular status, vision and foot exam.
- A functional assessment that includes activities of daily living (ADLs), daily activities, fear and the impact of fear.
- An environmental assessment including recent hospitalizations, floor surfaces, lighting and obstacles.

Use qualified screeners: The screening and assessment process needs to capture what the resident actually looks like and really needs to be conducted by an advanced practice nurse, medical director or the patient's primary care physician, Resnick recommends. "Screening is only as good as the screener," she emphasizes.

Every resident admitted to your facility should have comprehensive musculoskeletal and neuro exams as part of their physical. "Unfortunately not enough facilities do these and they are critical to the whole issue around falls," Resnick says.

In assessing ADLs, you need to focus not on what a resident typically does, but what he/she is actually capable of doing. "How many of you have ever been told that a certain resident can't walk, and then when you turn your back, somehow

they've made it to the bathroom? It's an amazing thing. So you really need to get a comprehensive assessment of capability," Resnick adds.

Residents who have had recent hospitalizations are at increased risk for falls because of the resultant decline in function. Another potential environmental factor to be on the lookout for is inappropriate footwear. "I have worked with facilities where you realize that everybody is falling because they don't have those footies with the nonslip soles. And if you just make them available, it can make a big difference," Resnick notes.

Don't stop there: Once the screening and assessment is completed, far too many providers simply put it in the chart and move on. "Nurses love to screen, because we complete it, check it off and move on. It's just so lovely, but that piece of paper can't catch a falling resident on the way down," Resnick warns.

Instead, the next step -- implementing the interventions that it takes to prevent the falls -- is the most important. Examples of interventions to try to reduce falls or the consequences of falls include:

- activities programs;
- function-focused care philosophies such as restorative care;
- patient education about safe sitting and standing;
- programs to help residents and families cope with and adapt to non-modifiable risk factors for falling;
- programs for patients who wander;
- reduction in the use of physical restraints;
- rehabilitation programs;
- staff education about fall risks and potentially helpful interventions;
- toileting and continence programs or a timed voiding schedule; and
- hip protectors.

For falls that are associated with getting out of bed, some options include: lowering a standard bed or using a low bed; nonskid mat at bedside. The use of full-length side rails is not recommended because their presence may result in injury to residents who try to climb over them, get caught in them, or try to climb out at the bottom of the bed.

Alarm bells: Although the use of bed and chair alarms has increased dramatically as many nursing facilities have become restraint free, there is only limited data supporting their efficacy in reducing the number of falls in long term care, Resnick notes. "Bed and chair alarms may facilitate the remote detection of somebody getting up, but obviously, they're not going to prevent the fall. They may get you there sooner, but that's about it."

Bed and chair alarms also may act as a reminder for the patient to ask for assistance. However, Resnick warns, "the efficacy of alarms is dependent on the diligent and timely response of the staff and the appropriate function of the alarms. I've seen instances where folks get into trouble because the alarm is the intervention and it's not being used appropriately or it's not functioning appropriately."

Other interventions include exercise and physical activity, medical assessment and management, medication adjustment, environmental modification and falls prevention education. "The bottom line is that you can't just do one intervention. If anything's going to work, it has to be multifactorial or multicomponent; otherwise you're not likely to succeed. Just educating your staff or families, for example, is not going to have the outcome you want. It takes a lot of hard work," Resnick emphasizes.

After the fall: A key part of Step 4 -- monitoring residents -- is re-evaluating the patient after they've fallen. The facility should have a written procedure for what staff should do if a resident falls, including who should be contacted following the fall and how the resident should be assessed and managed.

Post-fall assessment should look at relevant clinical finding such as vital signs, pain, swelling, bruising, and changes in function or cognitive status, or lack thereof. Although it is common practice in many long-term care facilities to do frequent vital signs or neurological checks, Resnick notes that there are no studies to demonstrate the utility of this practice. "No evidence supports observing patients for a fixed period of time after fall. And there's no regulatory requirement to do such frequent checks," she says.

Another common assumption is that everybody who falls must go to the hospital emergency room. "Some facilities think they have to send everybody who has fallen to a hospital emergency room, but it is not always necessary," Resnick says. Transfer to the hospital is appropriate if the resident has uncontrolled bleeding, major fracture or fracture likely to require surgical intervention, deformity of limbs or acute change in neurological status or cognition, she adds.

After a resident has fallen, staff should obtain relevant history regarding the resident's circumstances, including:

- current medication and med changes;
- a postural blood pressure and pulse;
- gait and balance evaluation;
- Tinetti balance assessment; and
- environment, including footwear/walking surface.

Jump in: "The bottom line here is to jump on it right away and look for 'hot ticket' items that are likely to make a difference. Sometimes it can be something simple, like the rubber tip on somebody's cane or walker is missing and no one noticed it. You need to take the time to really look for things like that. It doesn't always yield results, but if it does, even if it's only one situation, it's worthwhile," Resnick concluded.

Editor's note: Copies of the Clinical Practice Guideline for Falls in the Long Term Care Setting are available at: www.amda.com/tools/guidelines.cfm/