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Long-Term Care Survey Alert

Resident Assessment: Get To The Root Cause Of Falls:Follow This Decision-Making Tree When You Find A Resident On The Floor

Remember: Not all falls are created equal -- and some incidents aren't even considered a fall.

The next time you discover a resident on the floor, ask this critical question: Was it a fall, a faint or a fit?

The answer can go a long way toward developing a plan to prevent further incidents, suggested **Joseph Friedman, MD**, a neurologist speaking at the June 2004 **National Association of Directors of Nursing Administration in Long Term Care** (NADONA/LTC) conference in Orlando.

The first step: Ask the resident how he ended up on the floor. If he says he "woke up" there, ask the physician about ordering a Holter monitor to look for an arrhythmia, advised **Robin Bleier, RN, CLC, LHCRM, FACONA**, principal of **RB Health Partners** (Crystal Beach, FL) in a separate NADONA session on risk management.

Or in such a case, you might think "fit," especially if the resident has a history of epilepsy -- or if he recently had his anti-seizure medication dosage lowered. "Oftentimes, the resident can give you a history of seizures," Friedman tells **Eli**.

Another way to tell: "After a seizure, the person usually remains confused for about 10 to 15 minutes or might be very sleepy -- or he may have had an incontinence episode," adds Friedman. "Acognitively impaired person who is normally incontinent may seem lethargic, which might not generally be the case after a fall or faint -- unless he hit his head. And then all bets are off as to what happened."

Play it safe: "If the resident has an active seizure disorder, consider asking him to wear a helmet, especially if the resident has suffered head trauma related to his falls," advises **Karen Clay, RN, BSN, CWCN**, president of **Kare N' Consulting** in Brimfield, MA. "There are also padded wigs on the market, but these can be hot to wear." **Tip**: "Watch out for environmental conditions that can trigger seizures in residents with seizure disorders, such as a flickering fluorescent light on the blink," Clay advises.

Be a Fall Detective

It the resident tells you he fell, ask him what he was doing right before the incident -- and don't assume he's too cognitively impaired to give you the low down on the fall. "Sometimes people over estimate a resident's cognitive impairment and think he or she can't explain" what happened, Bleier cautioned NADONA attendees. The resident may say he slipped on the floor, tried to climb on the bed, his knee buckled or he got dizzy, says Friedman -- all important clues as to the cause of the fall.

Was a toileting accident or incontinence a critical factor? "If the resident was on the way to the bathroom, did he leak urine and fall?" Bleier asks. The resident may have urge incontinence and benefit from medication or quicker access to a toilet. Did the resident need to go to the toilet and then fall when he tried to get up on his own without assistance?

Did the resident report that he "froze" and fell -- or fell while he was trying to turn -- or found himself starting to walk really fast and couldn't stop until he fell? These are symptoms of Parkinson's disease and can cause a person to fall, according to **Bob Kann, PT**, director of rehabilitation at **Laurels of Shane Hill**, a skilled nursing and rehab facility in Rockford, OH. (For tips on how to identify residents with PD and reduce their risk of falls and fall-related injuries, see "Care Planning" & "Fall Prevention".)

When a Fall Is a Behavior

Does the person like to sit on the floor -- or do her falls appear to have an attention-getting quality to them? For example, one NADONA conference participant told about a resident whom staff repeatedly found on the floor with her dress smoothed as if she had positioned herself there.

"If the resident prefers sitting on the floor, then document that in the care plan," advises Clay. "Also choose seating options that embrace that preference, such as futons, bean bag chairs, etc.," she adds.

If the resident's fall appears to be an effort to attract attention, consult with mental health personnel to develop a behavior care plan, Clay advises. Be careful though, as most elderly people tend to under report falls because they fear restrictions to their mobility - or tend to deny their increasing frailty and dependence, Clay cautions.

But if you suspect a resident's falls may be behaviorally related, monitor and log the times the "behavior" tends to occur, Clay suggests. If you determine a pattern, pre-empt the falling behavior by meeting the resident's needs before he or she resorts to the attention-nabbing behavior. "For example, engage family to assist during some of the times when the behaviors occur (falls or self-positioning on the floor)," Clay advises. "Also tailor staff attention and activities during the times when the behavior tends to occur the most."

Determine Facility Shortfalls

Every time a resident falls, look at whether there were factors that could have prevented the incident, advises **Patricia Boyer, RN, MSM**, a nursing consultant with **BDO/Heritage Group** in Milwaukee. Say a newly admitted resident falls when she suffers a spontaneous fracture caused by undiagnosed osteoporosis. That fall won't fall in the same category in terms of facility culpability as a fall caused by a CNAusing a faulty transfer technique with a resident, Bleier noted in her presentation.

Risk management tip: If the fall wasn't in the facility's control, document your analysis to that effect, and ask the physician, nurse practitioner or physician assistant to sign it, advises Bleier. "Then take steps to prevent" another incident, she advised NADONA conference-goers.

In the example of the resident with osteoporosis, the facility can implement interventions to mitigate risk of falls and fall-related injuries, Boyer notes. Some of these interventions might include:

1. restorative nursing to improve the person's ambulation and prevent falls that could result in fractures;
2. positioning to help relieve unnecessary stress on the bones; and
3. diagnosis and treatment for the underlying osteoporosis, including calcium and vitamin D supplementation and medications.

Survey heads up: Expect surveyors to pay more attention to osteoporosis-related falls. A recent study supported by the **Agency for Healthcare Research and Quality** (HS13013) found that only 46 percent of older women with osteoporosis-related fractures received treatment in the six months following a fracture to prevent further fractures.

"Guidelines call for bone mineral density testing to detect bone loss and, when needed, medication to treat osteoporosis," says the AHRQ. (For an in-depth focus on osteoporosis assessment, treatment, fractures and falls, see the July 2003 Long-Term Care Survey Alert.)