MDS Alert

Case Study - SPECIAL SUPPLEMENT: FALL MANAGEMENT CASE STUDY

This facility's real problem turned out to be a care plan that was falling short.

If you're at your wit's end trying to figure out how to keep a resident from falling, the MDS may hold the elusive answers -- if you dig deep and connect the dots between the various sections.

Take the case of "Ted," a resident who fell 83 times in nine months in spite of 13 different care plan strategies (for a rundown, "Meet Ted. He Falls"). The caregiving staff had become increasingly frustrated with Ted's frequent falls and escalating agitation and aggressive behaviors. Sadly, Ted was becoming one of those residents about whom everyone says, "It's your turn to take care of him."

That's when the facility called in nurses **Sara Wright** and **Karen Russell**, members of the **Pennsylvania Restraint Reduction Initiative**, a grant-funded project to assist facilities in that state with restraint reduction, which is under the direction of **Kendal Outreach LLC**, an affiliate of the Kendal Corporation in Kennett Square, PA.

What the facility had done well: "The staff has to be congratulated because they had done a good job of looking at the basics in assessing Ted's fall risks," reports Wright. "They had also tracked his fall patterns and had done in-depth charting surrounding the fall events. They had attempted multiple interventions (see "Meet Ted. He Falls") and had adjusted his medications in response to his behaviors."

The problem was that staff viewed Ted's falls as a problem that they were trying to fix with various "things" and devices without first identifying the multiple risk factors causing him to fall.

Check These MDS Sections

That's where the MDS can provide a wealth of information. Here's what Wright and Russell zeroed in on to get a clear idea of why Ted kept falling and was combating staff every step of the way.

Section A (admission or reentry).

Studies show that fall risk persists for up to a month after a resident enters into a new environment, Wright says. And Ted had reentered the facility recently after a hospitalization to remove his gallbladder. Ted had received general anesthesia for the surgery, which can affect cognitive status, especially in an older person.

Section I (disease diagnoses).

Ted's list of diagnoses included COPD, congestive heart failure and coronary artery disease. Given the impact of surgery and general anesthesia on these conditions, Wright and Russell figured that Ted might have some degree of cardiovascular and cardiopulmonary complications affecting his fall status.

Next they compared Ted's diagnoses to his meds and found no supporting diagnoses for use of an antipsychotic medication (Zyprexa), an antidepressant (Celexa) and Ativan for anxiety.

Sections B and E (cognition and mood/behaviors). Staff was noting that Ted was having lethargy; in other instances, he was combative, restless and agitated. The MDS coding led Wright and Russell to suspect that Ted was having episodes of delirium.

Wright questioned whether Ted's anxiety might be due to low oxygen levels, which would make anyone anxious or dyspneic. "Given his diagnosis of CAD, he may also have been trying to tell staff he was having some chest pain, which is

why he was getting anxious," Wright notes. (Ted did have PRN oxygen prescribed, but would become agitated and remove the delivery apparatus.)

Ted also had a diagnosis of hypertension. But vital sign sheets showed that Ted actually had low blood pressure, although there was no way to tell from the flow sheets if Ted's low BP was connected to his falls -- or to when he received his antihypertensive medication.

Section K (oral/nutritional status) Oral and nutritional status showed that Ted had lost 20 pounds in 10 months (and 40 pounds overall since admission). Ted was also anemic, and that led to the question: Did he have a B-12 deficiency, which can contribute to muscle weakness and neurological/sensorium problems? Or might Ted be experiencing occult GI loss of blood or even overt loss?

Section O (medications). Ted had been treated for pneumonia and had been on two different antibiotics; one was a Quinolone, which can cause confusion.

Section C (communication/ hearing patterns). This section "jumped out" at Russell who noted that in the nine months during which Ted kept falling, he was coded on MDS as having a general decline in ability in comprehension and communication. Yet no one had reassessed Ted's ability to use the call light to ask for assistance. The facility hadn't provided a call bell or a call light with colored tape to help Ted find it. Nor was staff using flash cards with pictures of basic needs like a toilet, food or a glass of water.

Ted's behaviors tended to escalate to a fall event. "The notations in the chart indicate that staff was frustrated and Ted was frustrated," says Russell. "You feel for both parties. Ted was trying to communicate something is wrong with him and he wants the staff to recognize what it is ... but due to his impaired communication, we didn't know what he was trying to tell us. So that section of the MDS showing a resident's communication status is huge in terms of its impact on care and fall risk," Russell opines.

Section J2 (pain). Ted had a diagnosis of arthritis at multiple sites, but he was getting only PRN Tylenol, which is what he received after his gallbladder surgery. Ted consistently denied he was having pain, so the assessment ended there because the facility didn't have a pain-screening instrument for patient with cognitive impairments. "It's also hard to believe that Ted would not have pain after 83 falls," Russell adds.

"Yet the documentation read, 'Resident restless and yelling since shift started; swinging at staff. Voiced no complaints of pain. Ativan given for increased agitation.'" Wright and Russell, in fact, noted a pattern where staff administered Ativan for behaviors pre- and post-falls. "One has to consider what that intervention did to Ted's fall risk," Wright says.

In addition, Ted had a history of prostate cancer, and a radiological scan performed a few months earlier raised the question of whether the disease had spread to his bones. The facility hadn't pursued further work-ups because Ted's granddaughter, who worked in the facility, told the care team that the family didn't want Ted to go through invasive diagnostic testing.

Time for a New Game Plan

After reviewing Ted's MDS and medical record, Wright and Russell met with the interdisciplinary team and Ted's family to develop a new plan. Family members consented for Ted to have less invasive testing that confirmed the diagnosis of metastatic cancer. The care team discussed Ted's spiritual and comfort needs with the family.

The team came up with these specific interventions related to problems affecting Ted's fall risks and quality of life:

1. Orthostatic hypotension.

Once staff started doing BP readings on Ted sitting, lying and standing, they identified that he did indeed have this problem, which can certainly contribute to fall risk. So the caregiving staff started Ted on TED hose, and the physician assistant discontinued Ted's blood pressure med. Staff also raised the head of Ted's bed to 30 degrees so he wasn't lying flat in bed, which helps normalize blood pressure.

2. Fall risk posed by Ativan and Zyprexa. The prescribing clinician stopped these psychotropic drugs, which improved Ted's health status**.**

Clinical tip: Antipsychotic medications can increase a resident's gait problems and cause extrapyramidal side effects that can worsen falls, cautioned **M. Saleem Ismail, MD**, from University of Rochester in New York, who spoke at the June 2004 **National Association of Directors of Nursing Administration in Long Term Care** conference in Orlando, FL.

3. Pain. Ted started on a long-acting narcotic agent with a PRN medication for breakthrough pain, and a topical preparation for his joint discomfort.

As a result of pain management, Ted appeared to be comfortable and would agree to receive his PRN oxygen (which he'd been too fussy to do previously). He also began wearing hip protectors (which he'd previously refused) and elbow and knee protectors, as well.

Ted's appetite picked up, his weight stabilized, and his gait improved. A family member remembered a couple of special treats Ted liked and provided those as a frequent snack.

4. Quality of life. Staff realized they'd been so focused on getting Ted through the day without another fall or battle that they'd overlooked the fact that Ted's days were pretty miserable.

After brainstorming about how to put some fun into Ted's life, someone on the care team remembered that Ted had been a weekend farmer and had always used a John Deere lawnmower. So they put John Deere stickers on his cane to remind him to take it with him when he walked -- and as a gesture to recognize his avocation.

Ted also began to enjoy listening to his favorite music -- polka -- on his headphones. Staff had tried this activity before but Ted had been too fussy to keep his earphones on. Ted began to attend a variety of activities and appeared happy to be there with others. He'd sit in the hallways and sometimes sought out visitors and staff to hold hands with them.

Can't argue with this outcome:

Over the next six months, Ted had only seven more falls and no injuries -- a major improvement from the previous period. "We felt the staff did a nice job in giving this man his life back," Russell sums up.

In turn, Ted led to some system-wide changes in the facility's care protocols, including a new vital sign sheet that captures times when BP readings are taken. The facility also implemented a new pain assessment tool and behavioral assessment tool and new weight loss protocols.

Editor's Note: The above case study is based, in part, on a presentation by Sara Wright and Karen Russell at the fall 2003 **American Association of Homes & Services for the Aging** annual meeting and exposition in Denver.