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MDS Alert

In the Spotlight: Step Up Your Fall Prevention And Management Program

Follow this facility's lead to improve resident safety and prevent F323 citations.

If you're looking for best practice strategies to roll out a winning fall-reduction program, Dock Terrace has both.

The numbers speak of success: Initiated in 2004 with one year of collaboration with the **Pennsylvania Fall Interventions, Resources, Systems and Training** or FIRST program, the facility reduced fall rates by 20 percent over a year and then set a goal to reduce the rates by another 5 percent, which it met, according to **Joan Benner, RN**, assistant director of nursing for the Lansing, PA, SNF, which is part of the Dock Wood continuing care retirement community. Today, the SNF has its "ups and downs" with fall rates but remains between 10 to 15 percent lower than at the outset of its program, Benner says.

The facility is also restraint-free and doesn't use devices that can sometimes act as physical restraints. It was actually completely restraint-free when initiating the fall program and had not a lab buddy nor seat belt, etc., in the building, said **Neil Beresin, MSW**, with the Pennsylvania FIRST team, in a presentation at the fall 2007 A**merican Association of Homes & Services for the Aging** annual meeting.

In fact, said **Pat Lee, RN**, the facility's RNAC at the outset of the initiative, the SNF began focusing on falls once it had become restraint-free, eventually participating in the Pennsylvania FIRST program, a "train the trainer" model offered by the Pennsylvania Restraint Reduction Initiative.

5 Strategies Target Falls

So how does Dock Terrace stay a step ahead of preventable falls and fall-related injuries? For one, they don't wait to do the admission MDS to identify and care plan a resident's fall risks.

Reasoning: The facility found that residents were falling within the first three days to a week, Benner tells **Eli.** So now staff does a risk assessment on admission and re-admission in order to have a specific fall-related care plan in place on day one (see the risk assessment form on p. 94). They also try to collect information preadmission, when possible, to be able to implement preventive strategies when the resident enters the facility -- for example, a crash mat on the floor if the person has fallen out of bed previously.

If the person had frequent falls from a bed or chair and often tries to get up without assistance, staff implements a safety alarm for at least the first week to identify when he tends to get up to go to the bathroom. That way, "we can care plan to take the person to the bathroom before he tries to get up," Benner says. Safety alarms can also help if a resident gets restless and starts moving or trying to get up, triggering the alarm in time for staff to assist him, Benner adds.

Key point: Read your policies and if step No. 1 is "all residents are assessed for fall risk upon admission, readmission or with MDS changes" and step 2 says, "after a fall occurs ...," the facility has a problem, said **Sara Wright**, a geriatric nurse practitioner and Pennsylvania FIRST team member, in the AAHSA presentation. In between those two policies, the facility has to address implementing fall-prevention interventions based on the risk assessment.

No falling stars: Dock Terrace doesn't identify high-risk residents with fall symbols on the door, bed or chart, etc. At one point, it had a falling-star program, but staff realized that "almost 90 percent of our residents are at high risk for falls," says Benner. And the facility has such rapid turnover of residents these days that a falling-star program would be hard to keep up with.

Other fall-prevention strategies include the following:

• An intensive post-fall investigation and root-cause analysis of each fall. The facility developed an incident report form for falls and a post-fall investigation used when staff observes a resident fall -- or finds the person "down." "The investigation form highlights what's on the fall RAP," says Benner. As part of the investigation, she interviews staff, including the CNAs or anyone who was on the fall scene or came upon it. She also talks to anyone who knew anything about what was going on with the resident before the fall.

The interdisciplinary team discusses the fall at its daily meeting and decides what new interventions to implement immediately. Staff also does a root-cause analysis of every fall.

Critical point: If you don't do a root-cause analysis of each fall, the facility will have more injuries, cautions Benner. For example, suppose someone without a history of falling slips getting out of the bathtub. If staff assumes the person simply slipped and doesn't investigate, they may not find out that the person actually passed out when getting out of the tub, she says.

• A care plan flow sheet for CNAs. The two-page form includes a checklist format that identifies the resident's essential care requirements, including transfer and other ADL instructions, as well as fall safety measures, such as a low bed or safety alarms, Benner says.

• Staff assistance for high-risk residents when they walk. Due to the focus on providing help with ambulation, the facility has fewer fall-related injuries. For example, Benner is seeing more "assisted falls" where the staff person lowers the person to the ground when he begins to fall, Benner says. "We also use gait belts if indicated."

• A culture of accountability. The facility keeps staff on their toes about implementing the fall-prevention interventions on the care plan, Benner says.

For example, staff knows that managers may be asking them about a resident's fall care plan. And "we have disciplinary actions for staff members who don't follow the care plan and a [resident] falls as a result -- for example, if they don't use the lift or the type of lift specified for a transfer," she adds.