New York State Partnership for Patients

New Directions in Fall and Fall Injury Prevention

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Objectives

- Discuss essential elements and guidelines for fall and injury prevention programs
- Summarize synthesized literature for fall and injury reduction and surveillance in hospitals and long term care
- Translate actionable elements of a Fall Prevention Program: Prevention, Protection, Surveillance
- Segment high-vulnerable populations to protect from fall related injury
- Expand Post Fall Process

5 Essentials to Protect from Fall Related Injury (FRI)

Programmatic Shift

Change in assessment structures: add risk for FRI and Hx of FRI

Change in interventions: Environmental Redesign

Assess to protective interventions

Organizational Support

The Scope of Patient Risk "What's the Problem"

- While much effort and attention has been focused on reducing hospital adverse conditions, patient fall with injury, harm still occurs
- Need to "step up our game" and move at a more robust pace
- Share success stories; spread solutions

Sept 28, 2015: TJC Sentinel Alert: Preventing Falls and Fall Injuries

- Lead efforts to raise awareness of the need to prevent falls resulting in injury
- Establish an interdisciplinary falls injury prevention team or evaluate the membership of the team in place
- Use a standardized, validated tool to identify risk factors for falls and injury risk factors
- Develop an individualized plan of care based on identified fall and injury risks, and implement interventions specific to a patient, population or setting

Suggestions cont.

- Standardize and apply practices and interventions demonstrated to be effective, including:
  - A standardized hand-off communication process
  - One-to-one education of each patient at the bedside
- Conduct post-fall management, which includes: a post-fall huddle; a system of honest, transparent reporting; trending and analysis of falls which can inform improvement efforts; and reassess the patient
  - Conduct a post-fall huddle
  - Report, aggregate and analyze the contributing factors on an ongoing basis to inform improvement efforts.

Must Reads:

Clinics in Geriatric Medicine, Nov. 2010.

- D. Oliver, et al. Falls and fall-related injuries in hospitals. (2010, Nov). *Clinics in Geriatric Medicine*. 645-692

Levant, S., Chari, K., & DeFrances, C.J. (2015). Hospitalizations for patients age 85 and over in the United States, 2000-2010. NCHS Data Brief. No. 182. Available at: hppt://www.cdc.gov/nchs/data/databriefs/db182.htm.

AHRQ: Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices, Number 11. 2013

Nursing Economics, July/August 2016

Votruba, L., et al, "Video Monitoring to Reduce Falls and Patient Companion Costs for Adult Inpatients."

Hospital Falls: D. Oliver, et al. Falls and fall-related injuries in hospitals. (2010, Nov). *Clinics in Geriatric Medicine*.

- 30% to 51% of falls result with some injury
- 80% - 90% are unwitnessed
- 50%-70% occur from bed, bedside chair (suboptimal height) or transferring between the two; whereas in mental health units, falls occur while walking
- Risk Factors: Recent fall, muscle weakness, behavioral disturbance, agitation, confusion, urinary incontinence and frequency; prescription of “culprit drugs”; postural hypotension or syncope

Most effective, fall prevention interventions should be targeted at both point of care and strategic levels

- Best Practice Approach in Hospitals:
  - Implementation of safer environment of care for the whole patient cohort (flooring, lighting, observation, threats to mobilizing, signposting, personal aids and possessions, furniture, footwear)
  - Identification of specific modifiable fall risk factors
  - Implementation of interventions targeting those risk factors so as to prevent falls
  - Interventions to reduce risk of injury to those people who do fall

(Oliver, et al., 2010, p. 685)

Aging Hospital Population: 2010

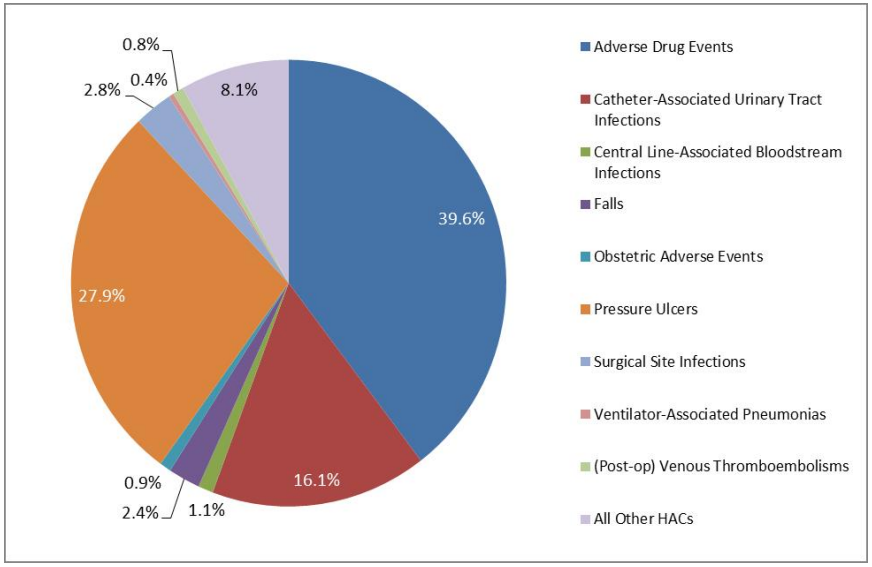
- 45% of the inpatient hospital population in the US was 65 years of age and older,
- among whom 19% were ages 75-84, and
- 9% were 85 years and older.

Levant, S., Chari, K., & DeFrances, C.J. (2015). Hospitalizations for patients age 85 and over in the United States, 2000-2010. NCHS Data Brief. No. 182. Available at: hppt://www.cdc.gov/nchs/data/databriefs/db182.htm.

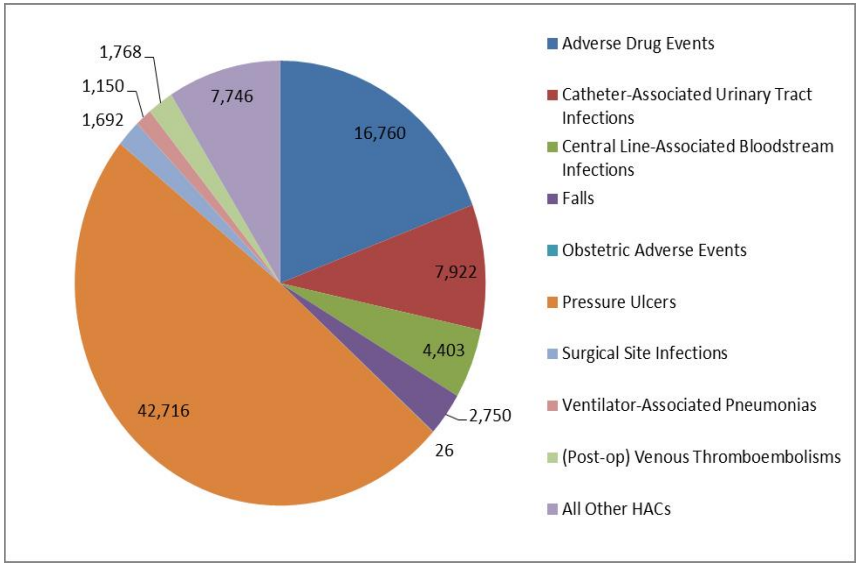
HELP! I'VE FALLEN AND I CAN'T GET UP!

Final 2014 AHRQ National Scorecard Data on HACs

2.4% decrease in falls but more work to do

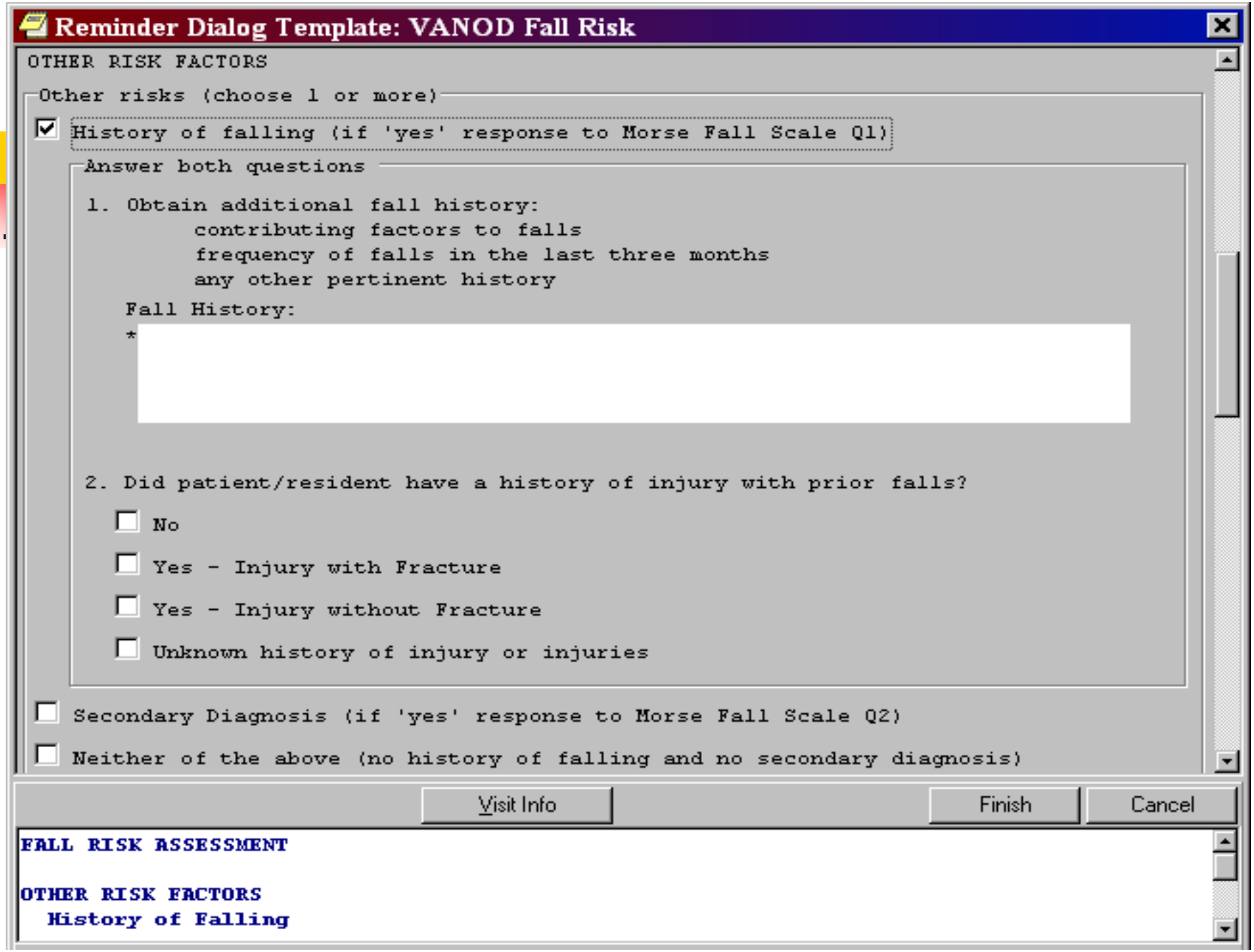


2,750 lives saved but we can save more



What are we doing? Why?

- Risk Screening vs. Assessment
  - Over reliance on screening tools
- Differential Diagnosis
- Individualized Care Planning
- Identify fallers from non-fallers
- Identify those with injury hx or at risk for injury
- Protect Patients from Injury
- Implement Surveillance / Detection Methods
- Redesign use of:
  - Bed Alarms
  - Sitters
  - Intentional / Purposeful Rounding


Reminder Dialog Template: VANOD Fall Risk
OTHER RISK FACTORS
Other risks (choose 1 or more)
History of falling (if 'yes' response to Morse Fall Scale Q1)
Answer both questions
1. Obtain additional fall history:
contributing factors to falls
frequency of falls in the last three months
any other pertinent history
Fall History:
*
2. Did patient/resident have a history of injury with prior falls?
No
Yes - Injury with Fracture
Yes - Injury without Fracture
Unknown history of injury or injuries
Secondary Diagnosis (if 'yes' response to Morse Fall Scale Q2)
Neither of the above (no history of falling and no secondary diagnosis)
Visit Info
Finish
Cancel
FALL RISK ASSESSMENT
OTHER RISK FACTORS
History of Falling

What About?

- The 85 y/o who says “No” to a history of recent falls?
- The patient who gets admitted because of a fall?
- The patient who falls in our care?
- Rules? Screening intervals

Current Interventions

- Are not working
- Are not individualized
- Can be reconsidered to revise your clinical practices and toolkits for prevention
- Can refocus to increase your safety net at the point of care

Measuring Orthostatic Blood Pressure

1. Have the patient lie down for 5 minutes.
2. Measure blood pressure and pulse rate.
3. Have the patient stand.
4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes.

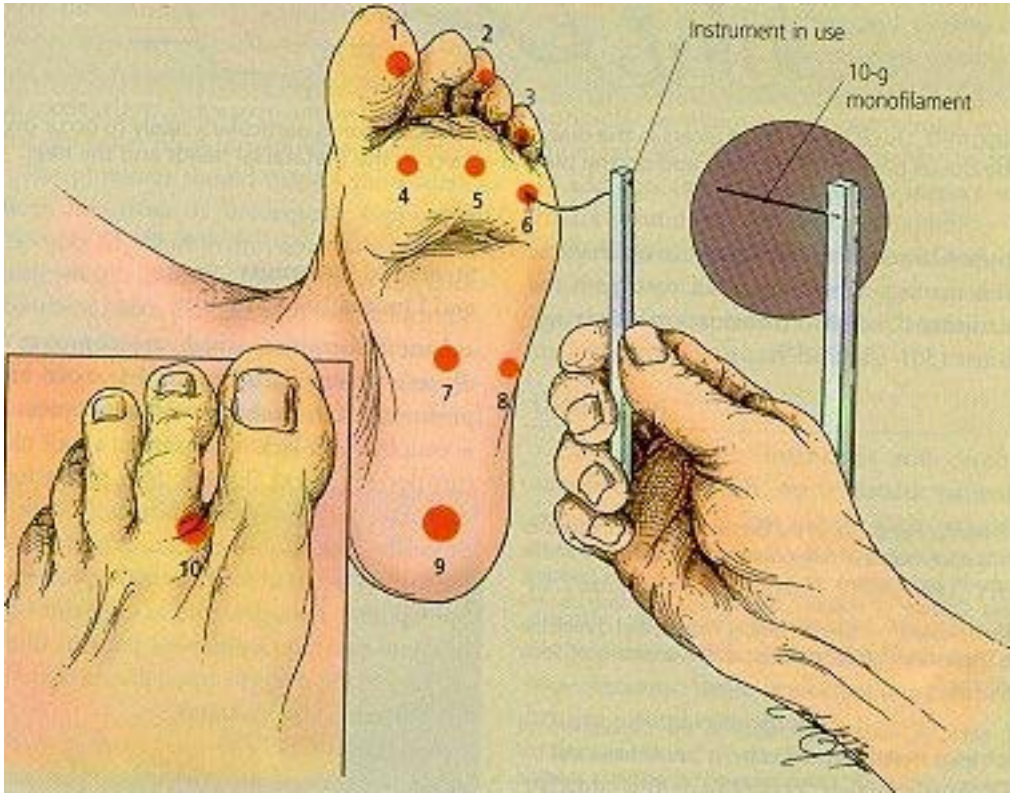
A drop in bp of ≥20 mm Hg, or in diastolic bp of ≥10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal.

Lying Down		**5 Minutes**	**BP** _____ / _____ **HR** _____	
Standing		**1 Minutes**	**BP** _____ / _____ **HR** _____	
Standing		**3 Minutes**	**BP** _____ / _____ **HR** _____	

For relevant articles, go to: **www.cdc.gov/injury/STEADI**

Sensory Monofilament Exam

- Determine if can feel pressure when eyes are closed



Targeted Interventions: Prevention + Protection + Surveillance

Prevention

- The act of preventing, forestalling, or hindering.

Plus Protection

- Shield from exposure, injury or destruction (death).
- Mitigate or make less severe the exposure, injury or destruction.

Plus Surveillance

- Detection, interaction, response - supports both prevention and protection.

Protection from Injury

Protecting Patients from Harm

Our Moral Imperative

Moderate to Serious Injury: A, B, C, S

- Those that limit function, independence, survival
- Age
- Bones (fractures)
- Bleeds / Anticoagulation (hemorrhagic injury)
- Surgery (post operative)

Universal Injury Prevention

- Educates patients / families / staff
  - Remember 60% of falls happen at home, 30% in the community, and 10% as inpts.
  - Take opportunity to teach
- Remove sources of potential laceration
  - Sharp edges (furniture)
- Reduce potential trauma impact
  - Use protective barriers (hip protectors, floor mats)
- Use multifactorial approach: COMBINE Interventions
- Hourly Patient Rounds (comfort, safety, pain)
- Examine Environment (safe exit side)

Age: > 85 years old

- Education: Teach Back Strategies
- Assistive Devices within reach
- Hip Protectors
- Floor Mats
- Height Adjustable Beds (low when resting only, raise up bed for transfer)
- Safe Exit Side
- Medication Review
- Criteria for Surveillance

Bones

- Hip Protectors
- Height Adjustable Beds (low when resting only, raise up bed for transfer)
- Floor Mats
- Evaluation of Osteoporosis
- Criteria for Surveillance

Bleeds/AntiCoagulation

- Evaluate Use of Anticoagulation: Risk for DVT/Embolic Stroke or Fall-related Hemorrhage
- Patient Education
- TBI and AntiCoagulation: Helmets
- Wheelchair Users: Anti-tippers
- Criteria for Surveillance

Surgical Patients

- Pre-op Education:
  - Call, Don’t Fall
  - Call Lights
- Post-op Education
- Pain Medication:
  - Offer elimination prior to pain medication
- Increase Frequency of Rounds
- Criteria for Surveillance

Real Time Surveillance

- Value of Virtual Surveillance
- Non-intrusive
- Interactive
- Vigilance
- Data Precision
- Witness to Events
  - What do you see?

Biomechanics of Fall-Related Injuries

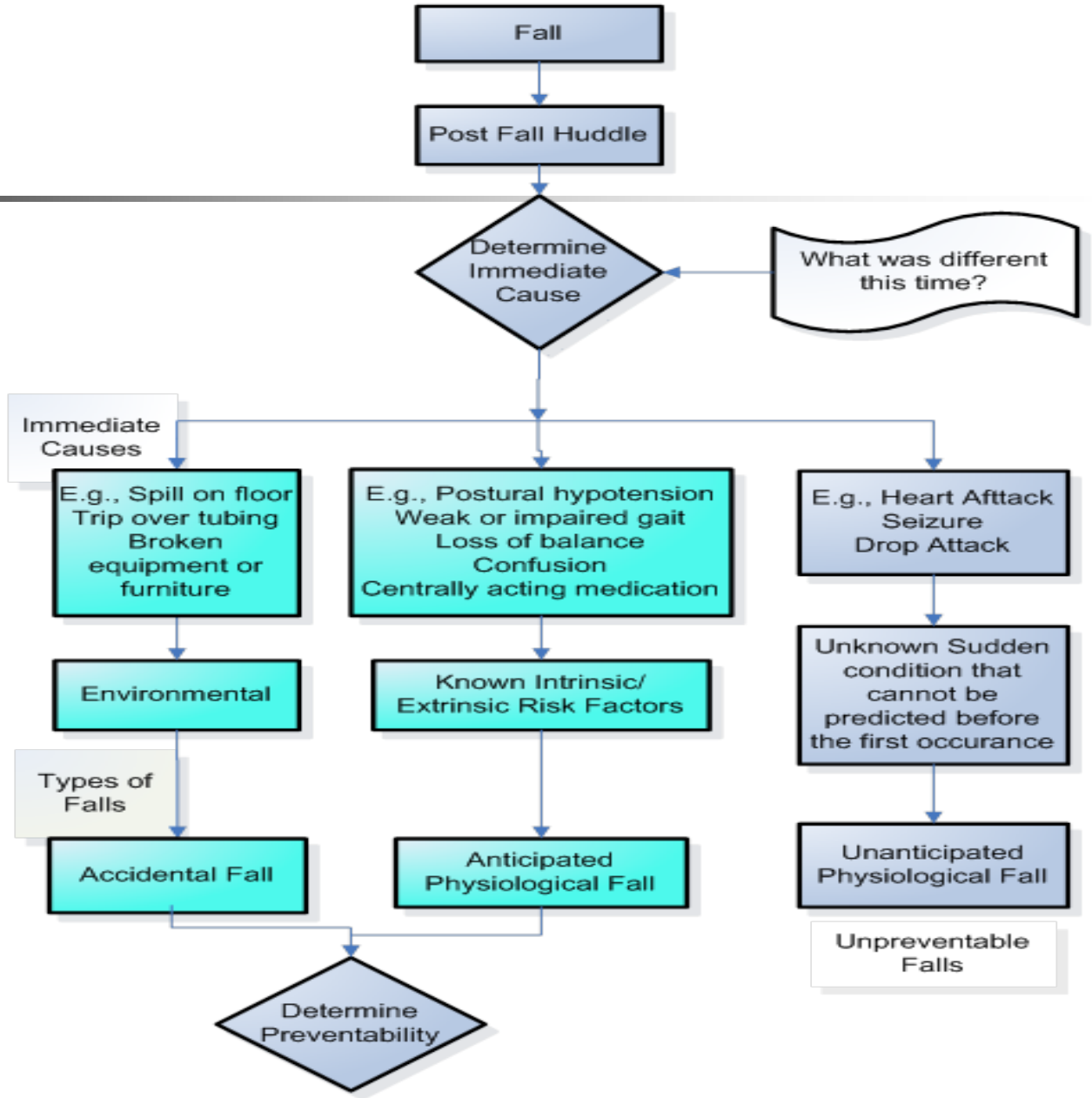
Understanding the "rate of splat" and its impact on injury

Falls from High Bed: Head First

Falls from High Bed: Foot First

Decision Tree for Types of Falls

Tuesday, April 22, 2014



Steps to the Post Fall Huddle

1. TL makes announcement
2. Convene within 15 mins with the pt/resident in the environment where the patient/resident fell
3. Conduct Analysis; Determine Root Cause of the Fall; if injury, Determine Source of Injury; Determine type of Fall
4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.
5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall
7. Communicate updated plan of care in patient/resident hand-off reports.
8. Complete EMR Post Fall Note

If the fall is witnessed….

- Benefits of Witnessing Event
  - Know the Root Cause
  - Know the Source of Injury
  - Precision of the Post Fall Huddle

Protect from Injury

- Remember:
- Protection from Injury is
  - separate and distinct
  - from fall prevention

Injury Protection

- Floor Mats
- Hip Protectors
- Helmets
- Eliminate Sharp Edges, esp. bathrooms
- Safe Exit Sides

Bedside Mats – Fall Cushions

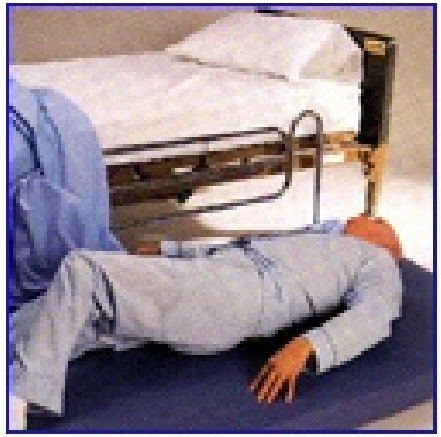
bedside fall cushion

Floor Mat

Floor Cushion

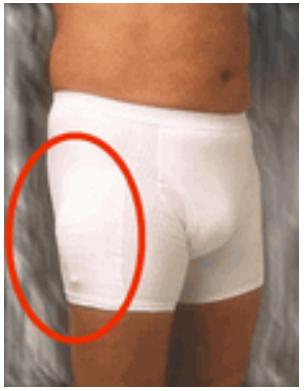
Tri-fold bedside mat

Roll-on bedside mat



Soft Fall bedside mat

Hip Protectors – Examples



Changing Your Conversation with Patients

- Do you label Patients / Caregivers: Non-Compliant?
- What does Non-Compliant Mean to You?
- How do you measure your effectiveness?
- How do you evaluate effectiveness of your teaching?

Partnering

- Patients
  - Need support and education to make good choices
  - Benefit from easy to use directives
  - Need to be accountable
  - Need practical examples to put principles into place
- Family
  - Partners in Care – Advocates, Information Gatherers
  - Messengers
  - Provide ongoing assessment in the home
  - Teach clinicians about their safe practices

Autonomy

- What does this mean to you?
- What happens after a fall?

“Teach Back”

- “Teach Back” Testing: what are the trends in patients’ difficulty to understand what is taught ?

  Ask the patient to describe or repeat back in his or her own words what has just been told or taught. Return demonstration is a similar technique used by diabetic educators, physical therapists, and others. When the health professional hears the patient’s description in her/his own words, further teaching can be accomplished to correct misunderstandings. Never ask whether patients understand; they always say “yes”.

When “Teach Back” Is Especially Important:

- New medications
- A new diagnosis
- Instructions for calling for help to BR
- Instructions for self care
  - e.g. ask, “How can you stay safe from falling in the hospital?”
- Patients are cautioned on how to prevent falls in the hospital
  - e.g. young male patients who suddenly have high doses of pain meds but want to toilet themselves. Ask, “How will you best prevent yourself from falling when you are given this powerful drug for pain that is known to cause falls?”

Ask Me 3

- Ask Me 3 materials are available at:

  http://www.npsf.org/askme3/

Ask Me 3 – Adapted for Falls

How many patients understand what we teach them?

- Teach patients with this format:
  - Their main problem putting them at fall risk
  - What they need to do to keep from falling in hospital
  - Why is it important for them to do this

- Check the family‘s understanding:
  - What is the patient’s main problem?
  - What can the patient to do to stay safe from falling in the hospital?
  - Why it is important for the patient to do this?

Teaching: After a Fall

- Reframe patient education curricula to include "what happens after a fall".
- What can we learn from this event?
- How can we work together to prevent this again?

Successful Implementation and Adoption

- Plan Implementation
- PDSA Cycle
- Track results of PDSA Cycle
- Measure Structure and Process Changes – expand data specific to your safety net!

I Fall A lot! Why?

Jethro and Mr. Goober

Oreo

What to do When you Fall...

VISN 8
Patient
Safety
Center
Tampa, FL

You Can Always Reach Me!

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