FALLS

What can cause a fall?

- When looking at possible causes of a fall, don't forget to look at the CLINICAL CONDITION

- QUESTION:
  What are some diagnoses that could contribute?

Review of Systems R/T Disease's

- Respiratory
- Cardiovascular
- Gastro-intestinal
- Musculoskeletal
- Urinary
- Integumentary
- Neurological

Respiratory System

- Upper Respiratory Infection
- Chronic Obstructive Pulmonary Disease- (COPD)
- Emphysema
- Asthma
- Pneumonia
- Bronchitis
- Sinusitis
- Nasal Congestion

- Tips for Effective Documentation
  - Respiratory
    - Rate
    - Chest Expansion (Symmetrical, etc)
    - Labored/Nonlabored
  - Oxygen Therapy
    - Liters, Nasal Cannula, Mask
    - How Often (Continuous, PRN)
  - Lung Sounds
    - Wheezing, Crackling, Rales, Rhonchi
    - Infiltrates (CXR)
  - Inhalers/Nebulizer Treatments
  - Antibiotic Therapy

Cardiovascular System

- Congestive Heart Failure
- Hypertension
- Angina
- Myocardial Infarction
- Ischemic Heart Disease
- Coronary Artery Disease
- Arrhythmias

- Tips for Effective Documentation
- Ensure progress note relate to the following symptomology and implemented plan of care
  - Assess for chest pain
  - Dyspnea
  - Orthopnea
  - Cough
  - Fatigue
  - Cyanosis/pallor
  - Edema
  - Noctura
  - Monitor Vitals (Blood Pressure, Heart Rate, Pulse, Temperature)

Gastrointestinal System

- Diarrhea
- Constipation
- Diverticulitis
- Chron's Disease
- Clostrium Difficile

- Tips for Effective Documentation
- Ensure progress note relate to the following symptomology and implemented plan of care
  - Frequency
  - Amount
  - Color
  - Consistency
  - Medical Management
  - Diet
  - Fluid Intake

Neurological Disorders

- Stroke
- Multiple Sclerosis
- Epilepsy/Seizures
- Parkinson Disease
- Alzheimer's
- Bell Palsy
- Brain Injuries
- Huntington's Disease
- Cognition

Neurological Disorders

- Tips for Effective Communication
- Ensure progress note relate to the following symptomology and implemented plan of care
- Mode of Transportation
  - Wheelchair
  - Gerichair
  - Electric Wheelchair
  - Ambulate
  - Assistive Devices
- Medication/Treatments
  - Analgesics
  - Anti-inflammatory
  - Anti-seizure medication

Referrals

- PT/OT/ST
- Restorative Services

Endocrine System

- Diabetes
  - Type 1
  - Type 2

- Tips for Effective Documentation
- Ensure progress note relate to the following symptomology and implemented plan of care
  - Monitor for Change in Mental Status (etc. Confusion)
  - Assess BGM Level
  - Assess the 3Ps
    - Polyuria
    - Polydyspia
    - Polyphagia
    - Breath Odor (Fruity Odor)
    - Excessive Sweating

Urinary System

- Renal Insufficiency
- Kidney Stones
- Urinary Tract Infection
- Incontinency
  - Stress
  - Urge
  - Functional
  - Overflow

Urinary System

- Tips for Effective Documentation
- Ensure progress note relate to the following symptomology and implemented plan of care
  - Frequency
  - Amount
  - Color
  - Odor
  - Sedimentation
  - Antibiotic Therapy
  - Isolation
  - Incontinency
  - Intake/output
  - Bladder retraining program

Musculoskeletal System

- Arthritis
- Osteoporosis
- Spinal Stenosis
- Contractures
- Degenerative Joint Disease
- Rheumatoid Arthritis
- Fibromyalgia
- Fractures/HX of FX

Musculoskeletal System

- Tips for Effective Documentation
- Ensure progress note relate to the following symptomology and implemented plan of care
- Mode of Transportation
  - Wheelchair
  - Geri chair
  - Electric Wheelchair
  - Ambulate
  - Assistive Devices
- Medication/Treatments
  - Analgesics
  - Anti-inflammatory
  - Ice Packs
  - Warm Compress
- Referrals
  - PT/OT
  - Restorative Services

Behaviors

- What is the behavior (be specific) and when did it occur
- Was there a resident to resident that caused the fall
- What triggers it if known
- On any current medication
- What interventions/medications were utilized
- Were the interventions/medications effective
- Does resident require hourly or Q 15 minute checks?

CLUES…… How far away did they fall?

- Place of fall (Bedside) – Look at Orthostatic
- 5 feet away – Look at Balance/gait
- >15 feet – Look at Strength /endurance
- In Bathroom/at commode – check contents of toilet. Was urine/feces in toilet/commode or was it on the floor?

Miscellaneous Causes

- New medication or over medicated
  - Side effects, adverse drug reactions, Black Box warnings
- Wandering vs. Pacing
  - Wandering – without a goal, usually provides comfort
  - Pacing – a need not met, rhythmic or repetitive
- Grabbing vs. Pushing
  - Grabbing – due to dizziness to stop from spinning – don't move
  - Pushing – to get away from being startled/attacked – slowly back away from resident

Miscellaneous Causes

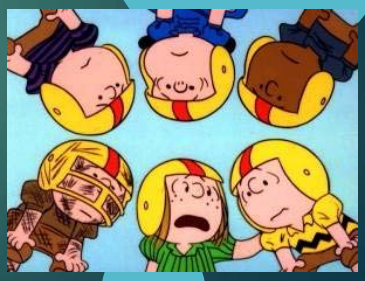
- Noise levels (staff, alarms, tv)
- Busy activity
- Visual conditions – contrast, poor illumination
- Personal items not seen or within reach
- Non-compliance
- Bed height incorrect
- Incorrect footwear

Miscellaneous Causes

- Equipment/assistive device not seen/available or not working
- Infection
- New environment/room
- Clutter/wet floors
- Glasses/hearing aid not in use or broken
- Age

Falls – Huddle

- Performed immediately after resident is stabilized
- Charge nurse has all staff working in the area of the fall meet together to determine root cause
- Review the 10 questions (next slide)
- Also ask staff:
  - Who has seen or has had contact with resident last few hours?
  - What was resident doing?
  - How did they appear/behave?



Falls – 10 Questions

- Are you OK?
- What were you trying to do?
- Ask resident or determine what was different this time?
- What is the position of the resident?
- What does surrounding area look like?
- What was the floor like?
- What was the resident wearing?
- Was the assistive device in place?
- Did the resident have glasses/hearing aid on?
- Who was in the area where the resident fell?

Falls – Be a CSI!!!!

- Use the '10 questions' as a guide during the HUDDLE
- When, where, how did you observe them, was it witnessed
- Why or what caused them to fall
- Look at the surrounding area for clues
- Ask what happened even if they are cognitively impaired
- Complete head to toe assessment (musculoskeletal, neuro if head involved, level of consciousness, pain)
- Obtain vitals and look for injuries

After a fall, what do I do?

- Complete the Charge Nurse Fall Investigation Form
- Complete the 'Fall Event'
- Complete the 'Fall Risk Observation'
- Document in progress notes what happened, be thorough
- Notify and document MD and legal representative
- Log on 24 hour report and/or any other documentation audit tool
- Update care card and care plan if any interventions were added or removed

After a fall, what does the nurse do?

- If possible head involvement, start neuro checks
- If labs recommended complete order and follow up with results. Don't forget to notify MD
- If x-ray/diagnostic tests needed, complete requisition and follow-up with results
- If safety checks recommended, start the 'Resident Observation Sheet'. Available online under the FORMS tab.
- If resident requires hospital evaluation, complete the transfer form. Attach all required documents
- Follow up with any other order/medication/treatment the physician may order

Documentation Example

- Example: Observed resident on her right side next to her bed on the floor mat with her head towards the foot of the bed. Her pants were down by her knees and covers of bed folded down. She stated she was taking her pants off to go to bed for a nap, lost her balance and fell. No injuries, no c/o pain, and didn't hit her head. Call light was not on. Instructed resident to use call light for help. After body assessment assisted resident to bed and call light given. Resident return demonstrated she was able to activate the call light. Dr. Plake and the husband were notified.

Documentation Example

- Example: Observed resident on the bathroom floor on the right side of the toilet under the sink. She stated she stood up using the grab bar but her hand slipped off and she fell to the floor and hit her head on the corner of the sink on the way down. There is a bluish purple hematoma approximately 2 inches in length with a 3 cm x 0.2 cm cut noted in the center of the hematoma. Small amount of blood noted to the corner of the sink. Complaint of pain to her head 5/10, neuro check initiated and WNL. Ice and pressure applied to the cut to stop the bleeding and control swelling. Resident stated she had no pain anywhere else and was able to move all extremities. Resident was assisted off the floor and to bed. MD was paged. After in bed, the resident stated she was having blurred vision and pupils were sluggish. The physician called back and was notified of the fall and the change in neuro assessment from the time of fall and when she was put back in bed. Order received to send to hospital for evaluation. Son, Michael was notified…….

BAD EXAMPLE. What is wrong?

- Found resident on the floor with pants soaked with urine and dried feces . Appears to have a massive laceration to his forehead. Blood poring out and oozing out on the floor about 2 quarts noted. Was screaming in excruciating pain and wanted to get up off the floor. Picked him up and put in bed for assessment. Complained of pain to his right hip and was externally rotated.

Management Follow-up

- Analyze ALL the data (Fall Risk Observation, Fall Event, progress note, BIM score, any interviews already done, etc.)
- Complete any other interviews if still needed. DO NOT allow staff to write their own. Listen and summarize what they tell you.
- Go to the scene and investigate. Look for possible causes
- Use the 'Fall Audit' tool as a guide to ensure all documentation is completed
- Complete the Fall Root Cause Analysis Form

Other Tools At Your Finger Tips

- Intervention Checklist
  - Reviews the possible interventions related to what happened
- Equipment Safety Checklist
  - Reviews the possible equipment that could have been involved

Fell From the Chair????

- You must determine how they fell out of or from the chair
- Example:
  - Did they lean forward and fall out
  - Did they slide off of the chair
  - Did they stand up and fall due to losing balance
  - Did they reach for something and fall out
  - Did they fall asleep and fall out
  - Was staff pushing them at the time and their feet got caught
  - Did chair roll back due to brakes not locked
  - And the list goes on.....

Fell From the Bed????

- You must determine how they fell out of or from the bed
- Example:
  - Did they lean forward to put on shoes/pants
  - Did they slip off of the side of the bed
  - Did they roll off while positioning or during sleep
  - Did they reach for something on the night stand or bedside table
  - Did they fall asleep while sitting on the side of the bed
  - Was staff positioning or providing care at the time they rolled off the bed
  - Did the bed move while the resident went to sit on the bed
  - Did they get tangled in the sheets

Fell From the Bed????

- You must determine how they fell out of or from the bed
- Example:
  - Was bed in lowest position
  - Did they slip while transferring out of bed (foot wear)
  - Were floor mats/antiskid strips in place
  - Adequate lighting
  - Did they fall during a staff transfer from bed to chair/chair to bed
    - Was staff using gait belt
    - Proper number of staff members
    - Mechanical lift

Fell While Ambulating????

- Was proper foot wear in place
- Were shoes tied, fit appropriately
- Did they trip on something
- Did they slip on wet floor
- Did they get weak and legs gave out
- Did they get dizzy/light headed and fell
- Do they have an unsteady gait
- Were they wearing their glasses
- Were they using their equipment (walker, cane, etc)

Fell While Self-Transferring????

- Was proper foot wear in place
- Did they lock their brakes
- Did their feet get caught on something (leg rest, chair wheel, etc)
- Did their feet get tangled during pivot
- Did they slip on wet floor during transfer
- Did they get weak and legs gave out
- Did they get dizzy/light headed and fell during trasnfer
- Do they have an unsteady gait once they stand
- Were they wearing their glasses to see the object they were needing to transfer to
- Were they using their equipment (slide board, brake extended, etc)
- Did they sit partially on the chair/bed and slip off

Avoid the Following…PLEASE

- Writing an intervention of 'Remind resident to …… or Educate resident to…' when they are NOT cognitively able to do so. Review their BIM score
- Writing an intervention that is not related to what caused them to fall. Example: they stood up, walked a couple feet and fell…intervention was dycem
- Writing for a UA/CS and it comes back negative and/or nothing else was done in the interim to determine cause or prevent future falls
- Staff reminders or staff education should not be listed under residents care plan interventions

Avoid the Following…PLEASE

- Fell from the bed but an intervention for the chair was implemented
- ALARMS. We should be trying to reduce the alarms especially if they are taking them off, shutting them off, cutting them off, etc.
- Alarms or restraints should not be your first choice
- Putting them on psychotropic medication just because they are frequently standing up from chair or getting out of bed
- Documenting they have a behavior when there is no previous supportive documentation

Teaching & Training

- Assessment of resident's readiness to learn
- Barriers to learning
- Type of instruction or teaching activity provided
- Response to instructions
- Results of the return demonstration

What would you do?

- **ROOT CAUSE:** Slide out of wheel chair due to poor positioning
- **INTERVENTION(S)?**
  - Dycem
  - Wedge cushion
  - Leg rests
  - Therapy referral

What would you do?

- **ROOT CAUSE:** Fell forward due to poor positioning
- **INTERVENTION(S)?**
  - Wedge cushion
  - Leg rests
  - Therapy referral

What would you do?

- **ROOT CAUSE:** Fell forward due to reaching for something off of the floor

- **INTERVENTION(S)?**
  - Reacher/grabber
  - Therapy referral
  - Ask for help (If cognitively appropriate)

What would you do?

- **ROOT CAUSE:** Fell from the bed while sleeping. BIM of 12

- **INTERVENTION(S)?**
  - Educate to sleep in center of bed
  - Concave mattress
  - Wing mattress
  - Bolsters
  - Floor mat

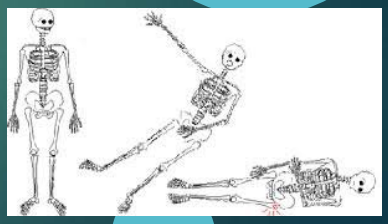
What would you do?

- **ROOT CAUSE:** Transferring out of bed. Slipped off edge of bed when he went to stand. Said his feet slipped when he went to stand. He had on socks.

- **INTERVENTION(S)?**
  - Anti-skid strips at bedside
  - Correct footwear
  - If able, put shoes on prior to getting up out of bed
  - Check height of bed

What would you do?

- **ROOT CAUSE:** Fell while self ambulating in hallway. Was 30 feet away from stationary chair he left from. Said his legs felt weak before he fell. Had appropriate foot wear on.
- **INTERVENTION(S)?**
  - Therapy referral
  - Walker
  - Temporary wheelchair



What would you do?

- **ROOT CAUSE NOT DETERMINED YET:** Fall #3 while self transferring to toilet
- **What would you do to help determine root cause?**
  - 3 day voiding diary
  - Toileting schedule
  - Therapy referral
  - Bladder scan/urology consult
  - Bathroom door alarm
  - Raised toilet seat
  - Review for HX UTI's
  - R/O orthostatic HTN

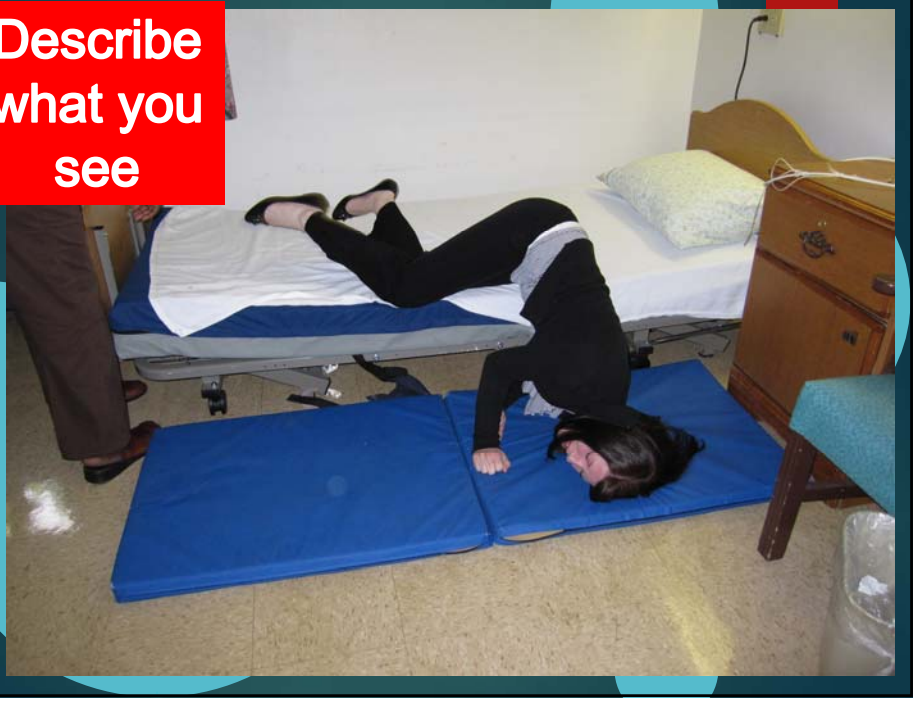
What would you do?

- **SCENERIO:** BIM 5, dependent for transfers, was using sit to stand and now unable to follow simple commands. Fell while using the sit to stand lift.
- **What would you do to help determine root cause?**
  - Evaluate for hoyer lift
  - Evaluate appropriate sling size
  - Refer to restorative
  - Observe the staff members for appropriate use of lift

LET'S PLAY CSI

Describe what you see

Describe what you see



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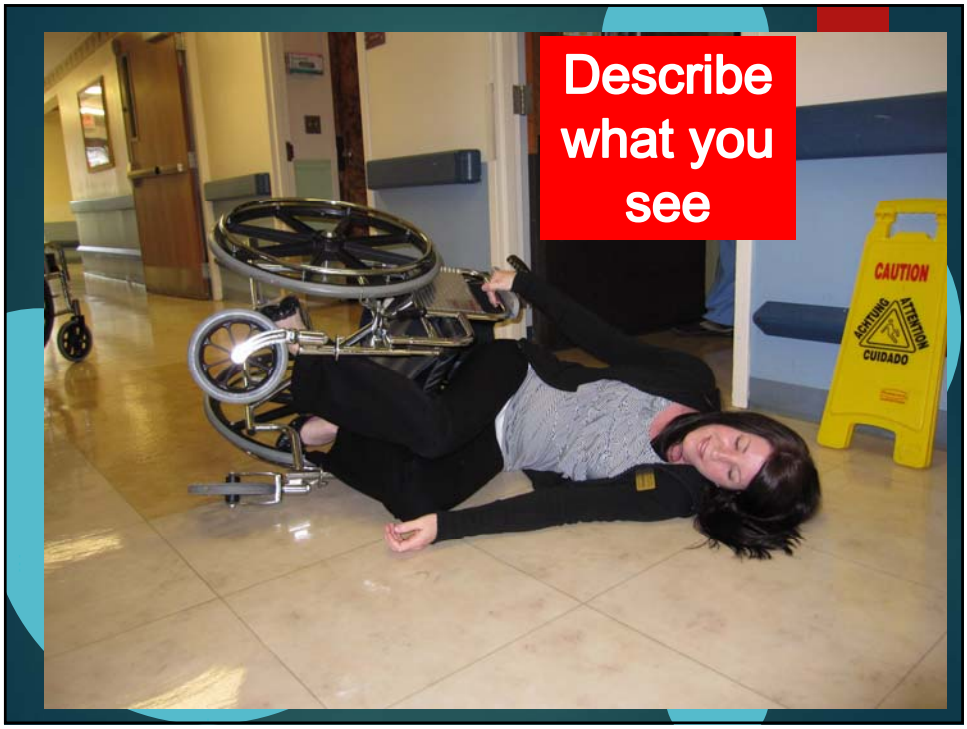
Describe what you see
CAUTION
ACHTUNG
ATTENTION
CUIDADO


Describe what you see

Describe what you see

Possible Tags R/T Falls

- F323 - supervision
- F309 – quality of care
- F246 – accommodation of needs
- F272 – comprehensive assessment
- F279 – care plan
- F311 – appropriate treatment service
- F369 – assistive devices
- F329 – unnecessary drugs
- F157 – physician/family notification

Key Points to Remember

- Most falls can be prevented
- A good investigation into the cause of the fall and an appropriate intervention can prevent future falls
- Fall prevention is a TEAM approach