



Week 8: Falls

Monday

Today is a great day for a discussion on Falls! Talk about environmental hazards that may contribute to a resident falling.

How many can your staff name (wet floors, poor lighting, incorrect bed height, improperly fitting wheelchair, poor shoes, or resident needs such as the need to use bathroom, items not in reach, call bell not in reach)?

If you notice any of these hazards, correct or report immediately! Involve physical therapy, occupational therapy and your pharmacy consultant in the fall prevention program.

Print the [Environmental Safety](#) resource and review with your team, then post

Did you know...?

According to the CDC, environmental hazards in nursing homes cause **16% to 27%** of falls among residents.

Such hazards include *wet floors, poor lighting, incorrect bed height and improperly fitted or maintained wheelchairs.*

Environmental Safety and Fall Prevention

1. Remove all clutter, unused items and equipment
2. Keep bed at correct height
 - When raised on the edge of the bed, the resident's feet should be flat on the floor and their legs should be slightly higher than their knee axles, otherwise indicated.
3. Use transfer belts when assisting residents to stand, transfer and ambulate.
4. Ensure adequate lighting
 - **REMEMBER:** Older adults need 2-3 times the amount of light to see.
5. Place personal items within easy reach
6. Ensure resident wears glasses when needed
 - **REMEMBER:** Many residents have impaired vision due to glaucoma, macular degeneration and cataracts.
7. Clear a path 2-3 feet wide from the bed to the bathroom
8. Ensure bathroom safety with handrail support and a raised toilet seat when indicated
9. Ensure resident is wearing well-fitted, non-slip shoes
10. Maintain wheelchair safety through regular inspection and repair
11. Involve PT and OT to assess transfer, mobility and wheelchair seating and implement modifications
12. Use prescribed lifting device
13. Use resident protective gear when indicated

Simple Strategies for Fall Management



it for other staff members to have for reference. Create a Falls bulletin board to display educational resources to reduce falls for your team.

Tuesday

Think about it!

How many times have you seen a resident:

- Try to stand, transfer or walk alone unsafely?
- Try to get out of bed alone?
- Walk or pace when too tired to be safe?
- Poorly positioned in either their bed or wheelchair?

Falls Prevention

Many falls occur when residents attempt to move about without assistance. Knowing your resident, purposeful rounding and anticipating their needs are simple strategies to prevent falls.

1. Rounding with the 4 P's
 - Check for Pain, location of Personal Items, need for toileting (Potty), and resident's Position.
 - Review the 4 P's of Purposeful Rounding: <https://bit.ly/PurposefulRounding>
2. Check in by ALL staff and volunteers
 - Each time upon entering the room, conduct a visual safety check of the environment and check in with the resident for current needs. This includes maintenance staff, housekeeping staff, aides, volunteers and administration. Ask for help from nursing staff when needed.
3. Consistent Staff Assignment
 - Know the resident so that their needs can be anticipated.
 - Understand personal history, personal preferences and behavioral patterns.
4. Regular Toileting
 - Know the resident's voiding pattern and schedule regular toileting.

Simple Strategies for Fall Management



How many times have you seen a resident try to stand, transfer or walk unassisted? It takes a team, working together, to reduce falls.

If you see a resident that looks unsafe, let someone know. Purposeful rounding can be conducted by anyone (housekeeping, dietary, maintenance, nursing, social services, activities and volunteers) who is "walking" in the facility. It does not have to be a nurse. Everyone in the department should be aware of residents and help keep them safe!

Print the [Falls Prevention](#) resource and share with team members, then post it for others to reference.

Wednesday

You talked about purposeful rounding yesterday. **Today, print and post the following resource on [The 4 P's of Reducing the Risk of Falls](#) and discuss them in depth with your staff.**

Also, download these [4 P's Cards](#) that can be cut out and shared with staff.

What are the 4 P's to reduce fall risk? Pain. Potty. Positioning. Possessions. Implementing purposeful rounding for all staff can significantly reduce fall risk.

The 4 P's of Reducing the Risk of Falls
 Prepared by Mary F. Oates, MS, RN, C-DE, Ohio Medicare Consulting, LLC

To help reduce the number of falls in our facility, we want to implement **Purposeful Rounding** for all staff. This poster can be used for all residents; however, we want to focus on all new admissions to our facility and our residents at high risk for falls.

The 4 P's are to be addressed by anyone who enters a resident room for any reason:

(P) Pain (P) Position (P) Potty (P) Possessions

Upon entering the room, you should:

Introduce yourself!
 For Example: "Mrs. Smith, my name is Sarah, and I will be your nurse, housekeeper, etc. today. I am here to clean your room, give you your medication, etc."

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Thursday

It is time to talk about engagement and sleep hygiene. Improving mobility, psychosocial well-being and sleep hygiene has been shown to reduce fall risk.

Print and post [Simple Strategies to Prevent Falls: Engagement and Sleep Hygiene](#) for your team.

Discuss ways your team can improve sleep for your residents.

Did you know...?
 Residents living with depression and/or dementia are likely to experience worse physical, mental and psychosocial well-being, creating a greater risk of adverse events, including falls.

Engagement and Sleep Hygiene
 Improving mobility, psychosocial well-being and sleep hygiene has been shown to reduce the risk of falls.

- Engage residents in their preferred lifestyle and activities on a regular basis.
- Encourage and involve residents in self-care and activities of daily living.
- Offer activities in which the resident can succeed.
- Include a range of resident and visitor activities.
- Offer volunteer work.
- Engage individuals in conversations from some of their favorite discussion topics.
- Offer access to gerontological activities such as cards, games, large print books, puzzles, etc.
- Bring residents to class/meetings for group exercise, music, bingo and other activities.
- Use iPads or other electronic devices, facetime, and other methods to engage residents in activities with families and others.
- Know the resident's bedtime and establish a consistent bedtime routine.
- Reduce noise at night.
- Assist residents to use technology devices to night music.
- Reduce medication fluids at night.
- Provide snacks as needed.
- Offer evening, non-sedating soothing evening activities.

Simple Strategies for Fall Management

HQIN

Friday

- Who is tracking falls in your facility and are they including it as part of QAPI? Let the team know.
- Is there a system of sharing information on falls and letting all members of the team know the facility's fall data?
- Was your team able to create a falls bulletin board?

Designate a "falls champion" today and continue to find great information on fall reduction to share with your team. Charts and graphs can be great to share! Download

POST FALL EVALUATION COMPONENTS FROM AMDA CLINICAL PRACTICE GUIDELINES		
Risk Category	Fall Risk	Post-Fall Evaluation
Fall History	Review history of falls	Review history of recent or recurrent falls and the circumstances of those falls
Medications	Review record for medications that could predispose to falls. Antihypertensives Anticholinergics Antidepressants (tricyclic, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors) Antidiabetic agents Antiepileptics Antihypertensives Antiparkinsonian agents Antipsychotic medications (typical and atypical) Benzodiazepines (short and long acting) Cholinesterase inhibitors Diuretics Opioid analgesics Sedative hypnotics Urinary antispasmodic agents Vasodilators	<ul style="list-style-type: none"> Review record for medications or combinations of medications that could predispose to falls Stop or reduce the dosage of as many of those medications as possible Review record for recent changes in the medication regimen that may have increased fall risk

the Health Quality Innovation Network (HQIN) [Nursing Home Falls Tracking Tool](#) and implement it into your team processes.