Of the 1.6 million residents in U.S. nursing homes, approximately half fall annually. About 1 in 3 of those who fall will fall two or more times in a year.
Consequences Of Falls For Residents

- Reduced quality of life.
- Increased fear of falling and restriction of activities.
- Decreased ability to function.
- Serious injuries.
- Increased risk of death.

Consequences of Falls For Residents

- According to data from the U.S. Centers for Disease Control and Prevention, about 1,800 elderly nursing home residents die each year from injuries sustained in falls.
- Thousands more suffer serious injuries, such as broken hips.
- Hard to quantify exact number due to the “official cause of death”.

Consequences Of Falls For Nursing Homes

- Increased paperwork for staff.
- Increased levels of care required for residents.
- Poor survey results.
- High insurance premiums.
- Lawsuits.
Alerting devices designed to emit a loud warning signal when a person moves.

Types of personal alarms:
- Pressure sensitive pads placed under the resident when they are sitting on chairs, in wheelchairs or when sleeping in bed.
- A cord attached directly on the person’s clothing with a pull-pin or magnet adhered to the alerting device.

Types of personal alarms:
- Pressure sensitive mats on the floor.
- Devices that emit light beams across a bed, chair, doorway.

Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
CMS Definition of a Fall

- Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
- Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).
- An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

Common Fall Risk Factors

Intrinsic
- Effects of aging on gait, balance and strength.
- Acute medical conditions.
- Chronic diseases – pathological fracture.
- Deconditioning from inactivity.
- Undesirable reactions.
- Poor safety awareness.
- Medication side effects.

Extrinsic
- Environmental hazards.
- Unsafe equipment.
- Unsafe personal care items.

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Extrinsic Environmental hazards.
Unsafe equipment.
Unsafe personal care items.
Purposeful Falls

- Unmet needs
- Personal History
- Cultural Significance

Common Interventions

- Orient to Call Light
- Verbal Reminders
- “Close Observation”
- q15 – q30 – q1 hour checks
- Medication Changes
- Personal Alarms
- Restraints

Restraints per MDS

“Physical Restraints’ are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily WHICH RESTRICTS FREEDOM OF MOVEMENT or normal access to one’s body”
Restraints per CMS

- CFR483.13(a) – F221: “The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or CONVENIENCE, and not required to treat the resident’s medical symptoms.”

Types of Restraints

- Chemical – psychotropics
- Physical
  - E Cushions or lap buddies
  - Merrywalkers
  - Seatbelts & Straps
  - Siderails
  - Recliners when they prevent rising
  - Locked wheelchairs (at times)

Negative Outcomes from Restraints

- Bruises
- Pressure ulcers
- Respiratory & cardiovascular complications
- Urinary incontinence and constipation
- Increased dependence in activities of daily living
- Impaired muscle strength and balance
- Increased agitation
- Increased risk for mortality caused by strangulation or as a consequence of serious injuries—for example, fracture, head trauma
Studies have shown that the use of personal alarms can promote -
- Pain
- Skin breakdown
- Incontinence
- Negative reactions
- Depression

And the biggie....FALLS!!!

Residents may get up to get away from the noise. We are taught to run FROM alarm sounds!
Residents may not move at all to avoid triggering the noise.
How do YOU feel at the end of the day after sitting in an all day conference like this one?

Sundowners is thought to be a result of the accumulation of stimuli throughout the day
How often do residents remove/disable/break alarms? Why?
How often do they protest verbally and physically when you re-attach an alarm?
Why do we ignore their wishes on this subject?
Common Objections

- “The family want us to use it.”
- “We don’t know what else to do.”
- “It prevents a resident from falling.”
- “It warns us that they’re moving and about to fall.”
- “It gets me there faster if they’re on the floor.”
- SO WHY ARE THERE STILL FALLS???

Are You Ready To Do This Thing?

Change is SCARY!
So Let’s Experiment!

Education & Preparation is Key

- Staff must be onboard first!
- Families next (plenty of fear there)
- Pick a small resident group to start
- Stay in contact with all involved
- Track your results
- Analyze not-so-desirable outcomes
- Celebrate success publically

DON’T GIVE UP!!

All Aboard!!

- You must provide staff with comprehensive education on what you are trying to accomplish. If they don’t understand, they will feel unfairly burdened with yet another “fad” that administration has dreamed up. Fear will take over, creating resistance to change.
Families…….

….Love their family members. Often times, their decisions and perceptions are slanted by fear, misperception & guilt. It is up to you to provide them with the tools to help them make informed decisions.

Family Care Conference

- Shouldn’t be a form letter, in the newsletter, via email or text
- SHOULD be a face to face conversation with resident, loved ones, and direct care staff present whenever possible
- Should give families a defined plan & timeline, & an open line of communication

But there are just so many residents, and the staff are afraid, and the families want them and the doctors want them, and it is just too overwhelming, the project is too big, how do we to it, and where in the world do we even start.........
How do you Eat an Elephant?

Start with a neighborhood/defined area.

QA meeting to establish plan, responsible staff & timeline.

Commit to at least 3 months no matter what the initial outcomes are.

Make sure everyone is informed.

Care plan and document steps.

Interview staff, family & residents frequently.

One Bite at a Time!

Start Small

- Start with a neighborhood/defined area.
- QA meeting to establish plan, responsible staff & timeline.
- Commit to at least 3 months no matter what the initial outcomes are.
- Make sure everyone is informed.
- Care plan and document steps.
- Interview staff, family & residents frequently.
Provide Reasonable Interventions

- Don’t just remove alarms and leave staff wondering what to do.
- Try a few residents per week.
- Meet with direct caregivers to identify resident habits and preferences.

MAKE A PLAN!!!
Protect and Encourage Sleep

- Survey myth: everyone who is incontinent must be changed every 2 hours all day and night
- Reality:
  - Extra absorbent incontinence products wick moisture away from the body.
  - Tissue tolerance testing evaluates each individual’s needs so an appropriate care plan can be developed and implemented.

Provide Meaning to the Day

- Identify what the person likes to do
- Take her for walks out of doors – or indoors if necessary
- Reduce time spent sitting and doing nothing – get up and dance!
- Consider 15 minutes of fame – The solution to individualized activities!!!

Shhh! Keep it Quiet

- Excessive noise will increase secretion of the stress hormone, cortisol. When startled or stressed, people try to get away from it.
- Don’t have the TV on all the time
- No overhead paging
- No yelling down the hall to other staff
- Consider “white noise” or soothing music playing softly in the background
Baby Steps?

- No alarms on any new resident
- No alarms on any resident who does not currently have one on
- If resident has not fallen in ____ (30) days
- If resident has a history of removing alarms
- If alarm appears to scare, agitate, or confuse resident
- If resident has fallen with an alarm on, do not put it back on

Deadline

“All restraints and/or alarms will be removed by _______ (date.)”

Track & Analyze Results

- Compare results with previous 3 months
- Look at types of falls & injuries, not just numbers
- Analyze each fall for root cause. Don’t allow knee jerk reactions of blaming lack of alarms. If a resident trips and falls walking down the hall, an alarm wouldn’t have helped.
Darn it.....She Fell Anyway!

What is the root cause of the fall?
- Need to use the bathroom?
- Pain?
- Sitting too long in the same chair?
- Boredom? Loneliness?
- Hallucinations? Delusions?
- Hazard?
- Medications?
- Position of her personal items?

Root Cause Analysis

Standard Of Practice
- Always ask the person what they were trying to do – even with cognitive impairment
- Immediate responders should implement a new intervention, if appropriate
- IDT should discuss the incident to validate or change the intervention
- Create an individualized plan of care

Celebrate Your Successes!!
**Additional Resources**


- CMS 2007 satellite broadcast training. For more information about the detriments of alarms in terms of their effects on residents see the 2007 CMS satellite broadcast training, “From Institutionalized to Individualized Care.” For an excerpt on alarm reduction, see website: [http://www.bandfconsultinginc.com/Site/Free_Resources/Entries/2009/7/2_Eliminating_Alarms__Reducing_Falls.html](http://www.bandfconsultinginc.com/Site/Free_Resources/Entries/2009/7/2_Eliminating_Alarms__Reducing_Falls.html)

- June 2010 Quality In Action Newsletter article, “What’s That Noise? An Account of the Journey to an Alarm Free Culture” By Morgan Hinkey, Administrator of Mala Strana Health Care Center, an AHCA Bronze Quality Award winning facility, September 2011.

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