

State of Science Update and Shifts on National Guidelines and Policy

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Overview

1. Update the burden of falls and state of science related to patient falls and fall-related injury.
2. Summarize updated national guidelines to shape fall and fall injury prevention practices
3. Differentiate Prevention vs. Protection vs. Surveillance.

Preventing Falls: Call for Action

- Transform healthcare for frailty associated with old age.
- Prevent falls identified as an effective strategy.
- BUT, major area for improvement in routine practice.

2003: IOM: Priority areas for national action: transforming health care quality

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



Compelling Evidence to Support Change: CDC

- **Every second of every day** in the US an older adult falls, making falls the number one cause of injuries and deaths from injury among older Americans.
- In 2014 alone, older Americans experienced 29 million falls causing seven million injuries and costing an estimated \$31 billion in annual Medicare costs, according to a new report published by the Centers for Disease Control and Prevention (released 092616)
- With more than 10,000 older Americans turning 65 each day, the number of fall-related injuries and deaths is expected to surge, resulting in cost increases unless preventive measures are taken.
- <file:///Users/owner/Desktop/2016%20Falls%20are%20leading%20cause%20of%20injury%20and%20death%20in%20older%20Americans%20%7C%20CDC%20Online%20Newsroom%20%7C%20CDC.webarchive> Accessed 011017

Estimates of Falls, Preventability, Cost

- 2010: Total HAC: \$5,980,000
- Falls: 200,000
- Falls (Baseline 2010 rate: 7.9 per 1,000 discharges)
- Preventability: 25% (2010/2011)
- Goal at launch of PfP: 50%
- Combined Goal (Preventability X Goal): 12.5%
- 2014 HAC Reduction Goal: 25,000 (fewer harm in 2014 compared to 2010)

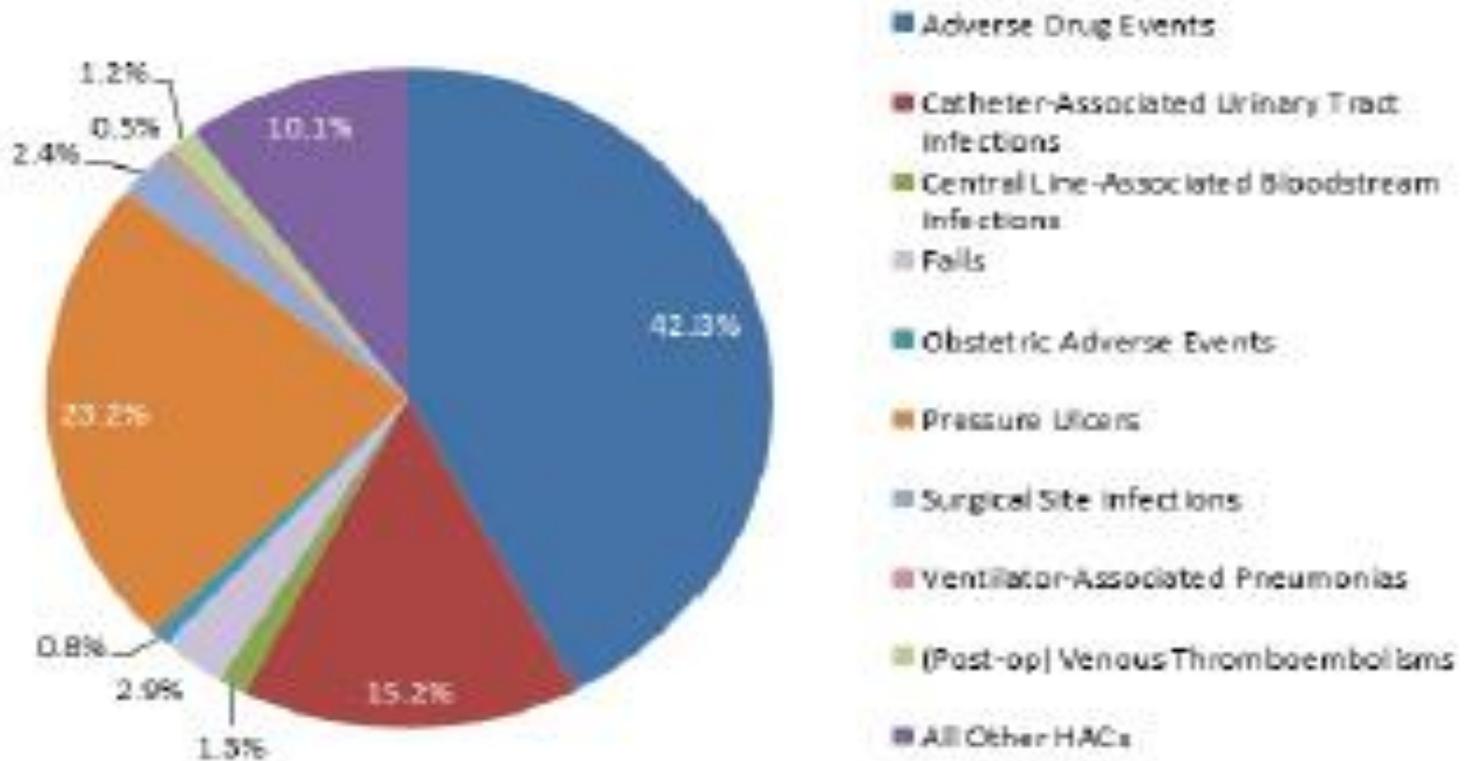
Projected Cost Savings (\$7,234 per HAC) and Life Savings (0.055 mortality risk) if goals met:

- \$180,050,000 cost savings
- 1,375 lives saved

2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. Rockville, MD: Agency for Healthcare Research and Quality; October 2015. AHRQ Publication No. 16-0006-EF.
<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html>

Where are we?

Change in HACs, 2011-2015 (Total = 3,097,400)



National Scorecard Estimates from Medicare Patient Safety Monitoring System, National Healthcare Safety Network Healthcare Cost and Utilization Project.

Interim 2014 AHRQ National Scorecard Data on HACs (Calculated November 19, 2015)

- Total HACs: 3,967,000 121 HACs/1,000 DCs
- Total Falls HACs: 260,000 7.9/1,000 DCs

No Change in Percent compared to 2010

HHS May 7, 2014: NDNQI reported 14.7 decrease
in Falls AND Trauma 2010- 4th Quarter 2013

<https://innovation.cms.gov/Files/reports/patient-safety-results.pdf>; accessed Jan 11, 2017

2019 PfP HIIN Goal

Hospital Improvement and Innovation Networks will work to achieve a 20% decrease in overall patient harm and a 12% reduction in 30-day hospital readmissions as a population-based measure from the 2014 baseline.

Falls: The Big Picture

- > 1 million patient falls occur annually.
- 20% of all hospital inpatients in the US fall at least 1X during hospital stay.
- 30% result in injury.
- 10% result in serious injury—fracture, head trauma.
- Over 95% of hip fractures are caused by falls.
- Patients >75 years now comprise 22% of hospital admissions.

Who dies if they fall?

- Very young and very old



2001 report, “Making Health Care Safer: A Critical Analysis of **Patient Safety Practices**,”

- became a cornerstone of other efforts (such as the National Quality Forum’s 34 “Safe Practices for Better Healthcare” list);
- ranked safety practices by strength of evidence;
- brought significant resources invested in efforts to improve safety;
- changed almost all health-care delivery organizations to regard safety as a *primary strategic priority*.

Patient Safety Practice (PSP)

- A PSP is defined as a type of **process or structure** whose application reduces the **probability** of adverse events resulting from exposure to the health care system across a range of diseases and procedures.

**2001 "Making Health Care Safer" Report*

- Q: How many of you are measuring structure or process? Specific to Fall and Injury Prevention

Making Health Care Safer II 2013

Co-Principal Investigators:

- Paul G. Shekelle, M.D., Ph.D., RAND Corporation Evidence-based Practice Center
 - Robert M. Wachter, M.D., University of California, San Francisco
 - Peter J. Pronovost, M.D., Ph.D., Johns Hopkins University
- Since 2001 report, a vast amount of new information on PSPs has emerged; **more agreement is now evident on *what constitutes evidence of effectiveness and the importance of implementation and context.***

Obj: To review important patient safety practices for evidence of effectiveness, implementation, and adoption.

Results: From an initial list of over 100 patient safety practices, the stakeholders identified 41 practices as a priority for this review: 18 in-depth reviews and 23 brief reviews. Of these:

20 PSPs had their strength of evidence of effectiveness rated as at least “moderate”.

26 PSPs had at least “moderate” evidence of how to implement them.

Results con't:

- 10 practices were classified by the stakeholders as having sufficient evidence of effectiveness and implementation and should be “strongly encouraged” for adoption.
- An additional 12 practices were classified as those that should be “encouraged” for adoption. This includes **multicomponent interventions to reduce falls.**

Chapter 19: Preventing In-Facility Falls

- Cochrane Reviews and Oliver, et al, 2006 (updated 2010) Systematic Literature Reviews

Isomi M. Miake-Lye, B.A.; Susanne Hempel, Ph.D.; **David A. Ganz, M.D.**, Ph.D.; Paul G. Shekelle, M.D., Ph.D.

- **17 Multifactorial Trials between 1999-2009** were reviewed.
- **Supplemented by 3 more recent large scale studies.**

Cochrane Review though...

- The most recent Cochrane review notes a “striking variability in type, targeting, intensity, and duration” within the fall prevention programs and *does not attempt to draw conclusions about which components might be most effective.*

Hospital Falls: we know.... (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, sign posting, 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)

Most common components of successful interventions (Oliver, et al)

- Post fall review: to assess potential reasons for a specific instance of a fall and to remediate possible contributing factors.
- Patient education.
- Staff education.
- Footwear advice.
- Scheduled and supervised toileting.
- Medication review: to assess for use of medication(s) that can affect mental alertness and balance.

Patient-specific risk factors include:

- Age (particularly age over 85, sometimes called the “oldest old”),
- Male gender,
- History of a recent fall,
- Muscle weakness,
- Behavioral disturbance,
- Urinary incontinence or frequency,
- Certain medications, and
- Postural hypotension or syncope.

Why PSP should work?

- First underlying assumption of each trial is the stated or implied understanding that falls have a **multifactorial etiology** and that attention to **multiple risk factors** will be more effective than an intervention that targets any single risk factor.
- A fall is usually the result of *interactions* between patient-specific risk factors and the physical environment.

What should work?

- Given the multifactorial nature of falls, a patient safety practice designed to assess and remediate multiple factors is believed to be more likely to be effective.
- Q: How many of you are measuring reduction of actual fall risk factors (patient and / or environment)?

How Has the Patient Safety Practice Been Implemented and in What Contexts?

- The ways in which fall prevention programs have been implemented and a description of contexts are lacking in most reports.
- Little description of structural organizational characteristics, existing infrastructure, external factors (patient safety culture, teamwork, or leadership).

It's Confirmed:

- Multi-component in-facility fall prevention programs result in statistically and clinically significant reductions in rates of falls.

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: <http://www.cdc.gov/nchs/data/databriefs/db182.htm>.

Clinical Judgment

- Evidence-based Practice
 - Versus
- Results of Scientific Inquiry

Where are we?

BEST PRACTICES:

PREVENTION

AGS Guidelines 2010

Assessment

Interventions

1. Obtain relevant medical history, physical examination, cognitive and functional assessment	1. Initiate multifactorial/multicomponent intervention to address identified risk(s) and prevent falls: Obtain relevant medical history, physical examination, cognitive and functional assessment
2. Determine multifactorial fall risk:	a. Minimize medications
a. History of falls	b. Provide individually tailored exercise program
b. Medications	c. Treat vision impairment (including cataract)
c. Gait, balance and mobility	d. Manage postural hypotension
d. Visual acuity	e. Manage heart rate and rhythm abnormalities
e. Other neurological impairments	f. Supplement Vitamin D
f. Muscle strength	g. Manage foot and footwear problems
g. Heart rate and rhythm	h. Modify the home environment
h. Postural hypotension	i. Provide education and information
i. Feet and footwear	
j. Environmental hazards	

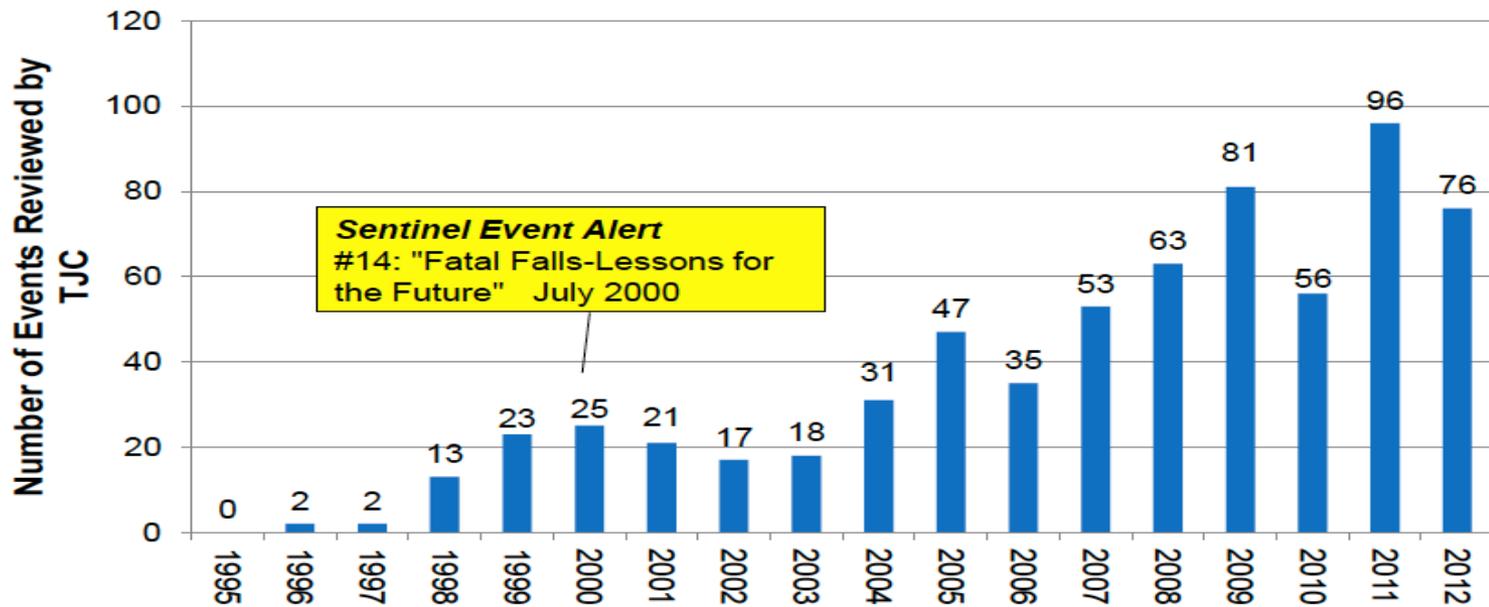
Falls at Bedside



TJC Sentinel Event Statistics

Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



TJC 2005-2016: Sentinel Events

#1: Wrong-pt, Wrong site, wrong procedure:
1225

#2: Unintended Retention of Foreign Bode:
1167

#3: Delay in Treatment: 1053

#4: Suicide: 972

#5: Op/Post-op Complication: 902

#6: Falls: 833

(Falls Events 2014-93, 2015-95, 2016-52)

2007 JCAHO Standard: Fall Prevention Program and Now

- Establish a Fall Prevention Program
- Evaluation
- Interventions
- Educate Staff
- Educate Patients and Families
- Program Evaluation
- Sept 28, 2015: TJC Sentinel Alert: Preventing Falls and Fall Injuries

Suggestions from TJC

- 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, assess fall 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 con't

- 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.

Shifting

- From Reducing Falls to Protecting from Fall Related Injury.
- Integrate Injury Risk / History on Admission.
- Implement Universal Injury Reduction Strategies.
- Implement Population-Specific Fall Injury Reduction Interventions.

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.

Discussion – Questions?

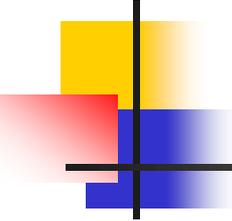
- I hope this helps!



Best Practices Approach: Fall Risk and Injury Reduction

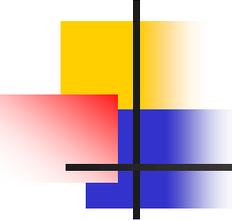
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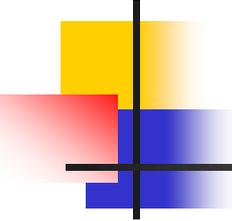
Objectives

- 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



Patient Harm... remember the news?

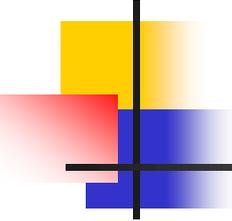
- IOM: To Err Is Human, Shaping the Future of Healthcare (1999)
- 48,000 perhaps as much as 95,000 die each year in hospitals as a result of medical errors that could be prevent



Dr. J. James 2013 Update

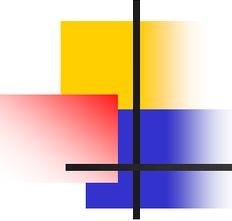
- Provided updated estimate of patient harm
- Examined studies 2008-2011
- MDs had to concur on final adverse events then classify the severity of harm
- True number of premature deaths associated with preventable harm estimated at more than 400,000/year
- Serious harm 10-20 fold more common than lethal harm

Patient Safety America, Houston, TX. A new, evidence-based estimate of patient harms associated with Hospital Care (2013). *Journal Pt Safety*, 9: 122-128.



Conclusions

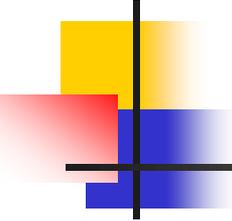
- Epidemic of patient harm in hospitals must be taken serious if to be curtailed
- Fully engage patient and their advocates during hospital care
- Systematically seek the patient voice in identifying harms
- Transparent accountability for harm
- **Intentional correction of root causes of harm**



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



5 Essentials to Protect from Fall Related Injury (FRI)

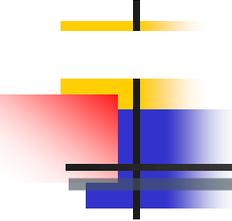
**Programmatic
Shift**

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

**Change in
interventions:
Environmental
Redesign**

**Assess to
protective
interventions**

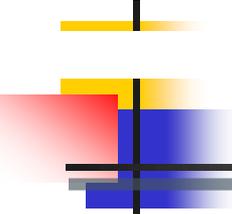
**Organization
al Support**



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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).

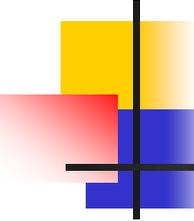
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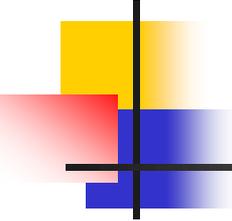
AHRQ: Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices, Number 11. 2013

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*.

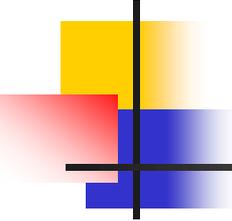
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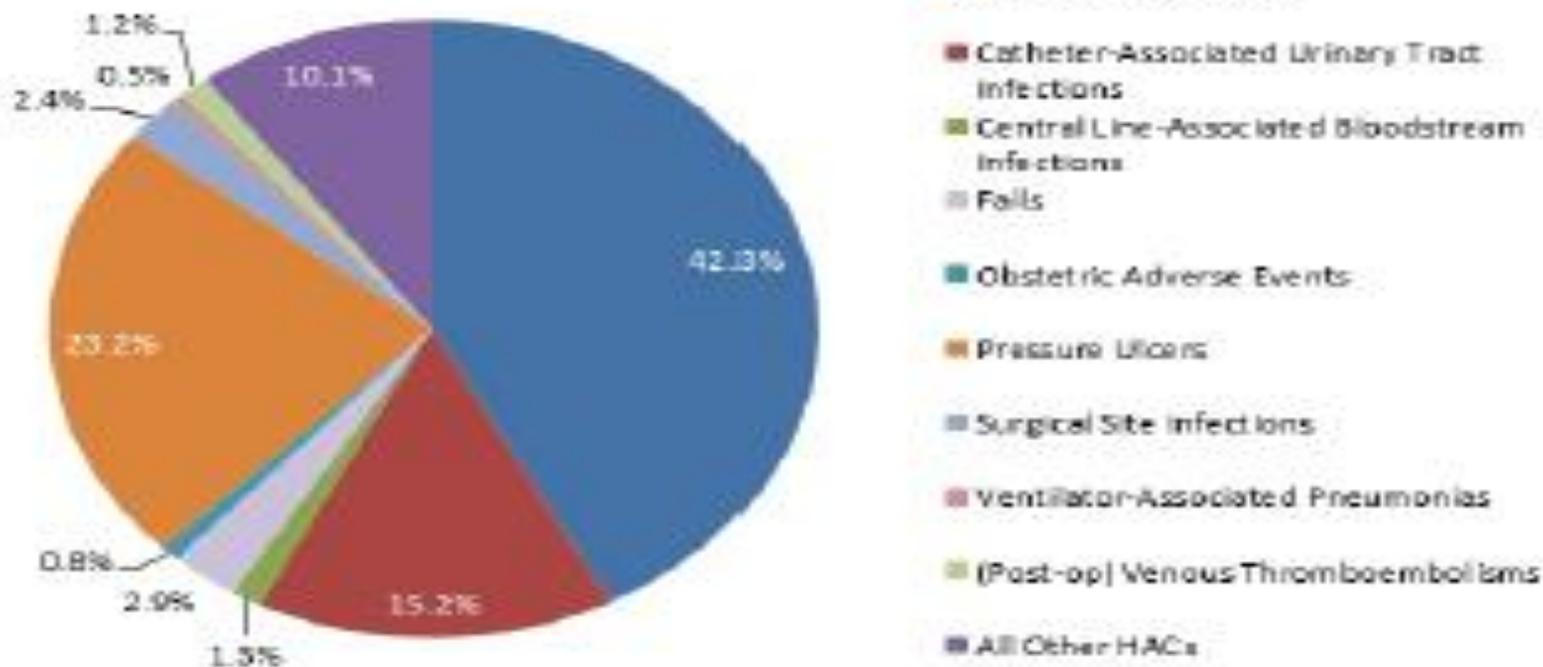
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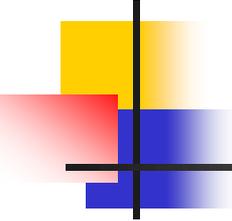


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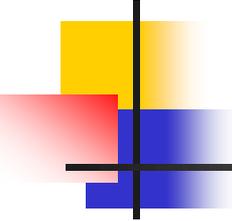


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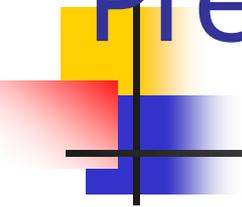
What are we doing? Why?

- 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



Let's Bust Myths

- Challenge current practices so we can individualize fall and fall injury preventions.



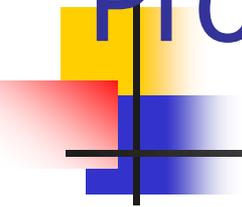
Prevention Myth Busters

What is prevention?

- The act of preventing, forestalling, or hindering

Myths:

- 1) You can prevent all falls
- 2) You can predict the likelihood of all falls
- 3) Patients are going to call for help
- 4) Strategies to prevent all falls are the same



Protection Myth Busters

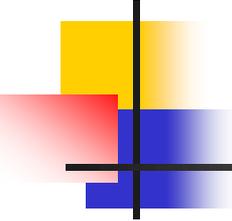
Myths:

What is protection?

Shield from exposure, injury or destruction (death)

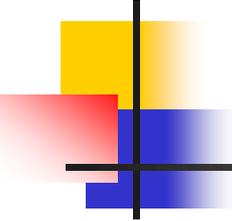
Mitigate or make less severe the exposure, injury or destruction

- 1) Assessing fall risk is the same as assessing injury risk
- 2) All patients have the same risk for injury
- 3) Interventions to prevent falls are the same as interventions to prevent injury



Current State

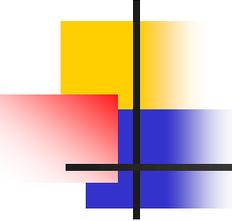
- Overall lack of robust falls evidence has led to the development of bad habits
- Over reliance on practices contrary to evidence
- Patients minimized to a score
- Working harder, applying more pressure
- Patients and families seen as the problem



Let's Share!

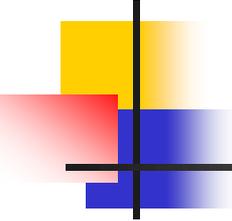


- What are your **barriers** to shift practice to population-based, individualized care planning
- What are your **facilitators** to shift practice to population-based, individualized care planning



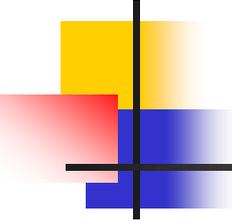
Current Interventions

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



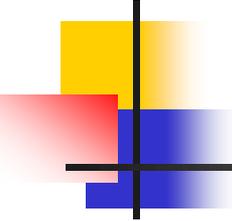
What can we change to move faster?

- Current situation:
 - Over-reliance on Fall Risk Screening
 - Insufficient Risk Assessment
 - Lack of Differential Diagnosis: Pathophysiology Underlying Fall Risk Factors
 - Undetermined Range of Severity – Don't know vulnerability – Level of Risk
- Understand that just about everyone is at risk for a fall
- Let's STEP UP our game!
- Set and be accountable for achieving bold goals. In our care:
 - No one dies from a fall
 - No one breaks a hip
- **Mitigate or eliminate patients' modifiable fall risk factors**



Screening to Assessment

- History of Falls
 - Screen: yes or no
 - Assessment: based on positive or negative screen response
 - History of fall injury
- Assessment must be comprehensive
 - Pre-Mobility (postural hypotension, sensory neuropathy; proprioception)
 - Mobility Status (gait, balance, assistive devices)
- Required for rest of nursing process
- Assessment must involve interdisciplinary team (nursing referrals to PT, PharmD, etc)



Fall Risk Scales/Tools

- Morse Fall Scale- 1989
- Schmid Fall Risk Assessment Tool - 1990
- Hendrich I - 1995
- Conley Scale for Med Surg - 1999
- Hendrich II- 2003
- Johns Hopkins Fall Risk Assessment Tool (FRAT) - 2005
- HD Nursing - 2013

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

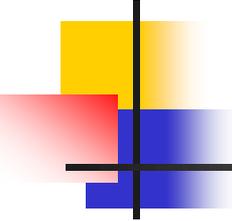
Finish

Cancel

FALL RISK ASSESSMENT

OTHER RISK FACTORS

History of Falling



What About?

- The 85 yo 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

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.

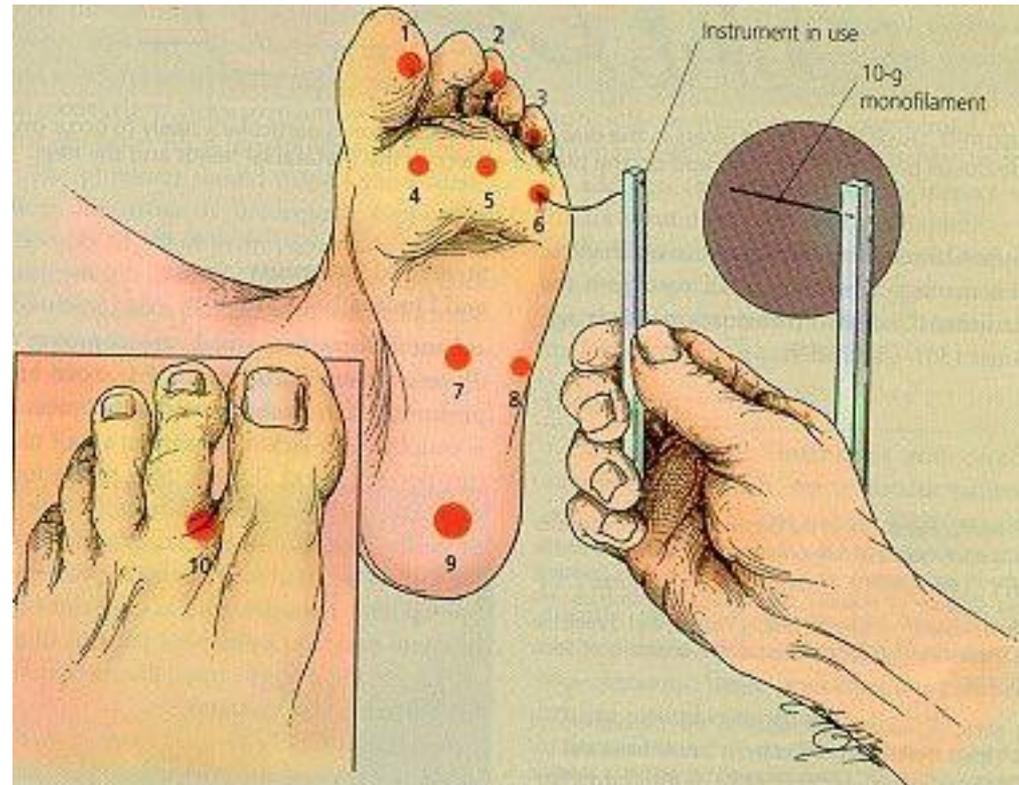
A drop in bp of ≥ 20 mm Hg, or in diastolic bp of ≥ 10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal.

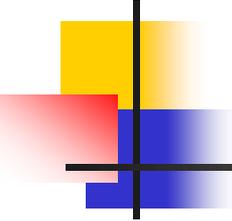
oms

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

Sensory Monofilament Exam

- Determine if can feel pressure when eyes are closed





Targeted Interventions: Prevention + Protection + Surveillance

Prevention

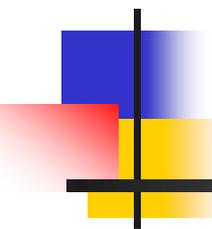
- The act of preventing, forestalling, or hindering.

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.

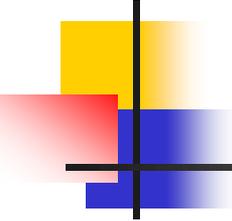


Protection from Injury

Protecting Patients from
Harm

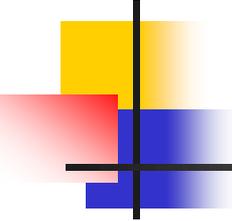
Our Moral Imperative





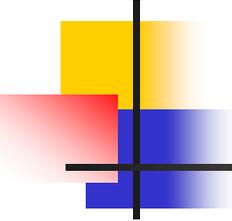
Moderate to Serious Injury: A, B, C, S

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



Universal Injury Prevention

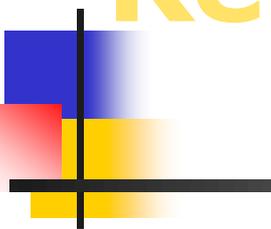
- Educates patients / families / staff
 - Remember 60% of falls happen at home, 30% in the community, and 10% as inpts.
 - Take opportunity to teach
- Remove sources of potential laceration
 - Sharp edges (furniture)
- Reduce potential trauma impact
 - Use protective barriers (hip protectors, floor mats)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



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



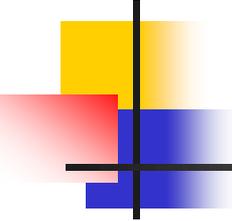
*Understanding the
"rate of splat" and its
impact on injury*

Falls from High Bed: Head First



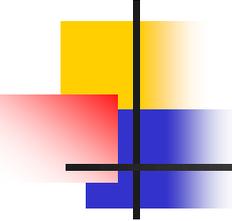
Falls from High Bed: Foot First





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



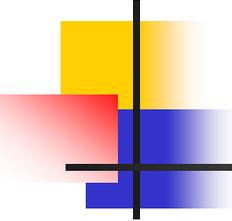
Tri-fold bedside mat



Roll-on bedside mat



Soft Fall bedside mat

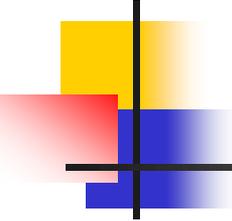


Hip Protectors



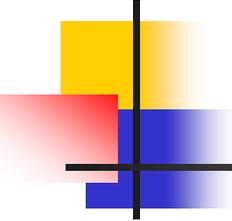
Hip Protectors – Examples





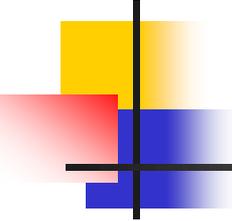
Survival and Functional Outcomes after Hip Fx among NH Residents

- Outcomes after hip fractures among long term care nursing home resident
- Data Sources: Medicare Claims Data; Retrospective cohort study, n=60,111 medicare beneficiaries residing in NHs who were hospitalized with hip fracture between July 1, 2005-June 30, 2009
- Neuman, M.D., Sibling, J.H., et al., (2014), JAMA, 174(8) 1273-1280



Outcomes:

- Of 60,111 pts, 21,766 (36.2%) died by 180 days after fracture
- Among pts not totally dependent in locomotion at baseline, 53.5% died or developed new total dependence within 180 days
- Function declined substantially after fracture across all ADL domains assessed

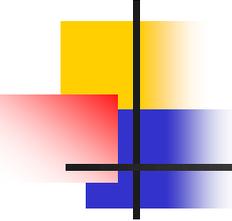


In adjusted analyses:

The greatest decreases in survival after fx occurred with:

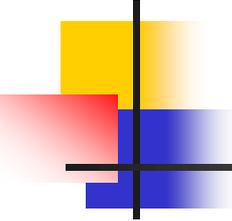
- Age older than 90 yoa
- Non-operative fx management
- And advanced comorbidities

(All analyses with statistically significant hazard ratios)



What are your plans?

- What will you do differently to protect your patients?



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!

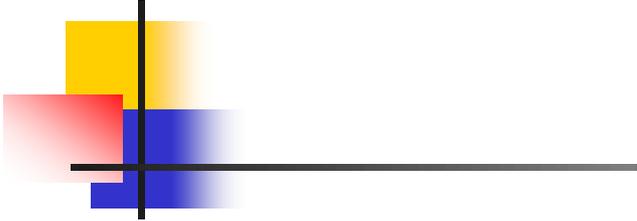
I Fall A lot! Why?



Oreo

Jethro





**What to do
When you
Fall...**



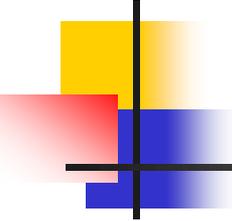
**VISN 8
Patient
Safety
Center
Tampa, FL**

Thank You

If you Fall
Tell
Someone



pquigley1@tampabay.rr.com



You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com

Focus on Protection from Injurious Falls, Population-based Approach to Injury Reduction

Pat Quigley, PhD, APRN,
CRRN, FAAN, FAANP

Nurse Consultant

pquigley1@tampabay.rr.com

Overview

1. Profile changing epidemiology of the aging hospital population
2. Review latest breakthrough and nationally adopted techniques in fall-related injuries in the aging population
3. Implement population-specific fall and injury prevention practices across settings of care

Preventing Falls: Call for Action

- Transform healthcare for frailty associated with old age.
- Prevent falls identified as an effective strategy.
- BUT, major area for improvement in routine practice.
 - 2003: IOM: Priority areas for national action: transforming health care quality

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)

Making Health Care Safer II 2013

- Chapt 19: Preventing In-Facility Falls
- **Includes Hip Protectors!**

Head Injuries

- The CDC reports falls as the leading cause of TBI for adults aged 75 years and older (CDC, 2015a).
- Of all the TBI-related ED visits in the United States during 2006 to 2010, the 65-years-and-older age group accounted for 81.8% of the TBI-related ED visits (CDC, 2015b). This age group also has the highest rates of TBI-related hospitalization and death.

Population Profile

- Groups at risk for the development of TBI include men, who are twice as likely to sustain a TBI, adults aged 75 years or older, and African Americans who have the highest death rate from TBI (CDC,2015; NCIPC).
- Older adult residents who experienced head injuries from a fall were more likely to live in assisted living (47.9%; $p < .04$) and to be walking at the time of their fall (69.0% versus 36.1%) compared with older adult fallers without a head injury (Gray-Miceli, Ratcliffe, & Thomasson, 2013).

Hip Fractures

- The CDC estimates that more than 95% of hip fractures are caused by falling, often sideways, on the hip (CDC, 2015).
- Annually, at least 258,000 hospital admissions for hip fracture among those 65 years and older occur nationwide (CDC, 2015).

Population Profile

- Women, especially White women, carry the greatest risk for hip fracture compared with men, African American, or Asian women
- An underlying diagnosis of osteoporosis increases risk for fall-related hip fracture (National Osteoporosis Foundation, 2013).

Survival and Functional Outcomes after Hip Fx among NH Residents

- Outcomes after hip fractures among long term care nursing home resident
- Data Sources: Medicare Claims Data; Retrospective cohort study, n=60,111 Medicare beneficiaries residing in NHs who were hospitalized with hip fracture between July 1, 2005-June 30, 2009
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Outcomes:

- Of 60,111 pts, 21,766 (36.2%) died by 180 days after fracture
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- Function declined substantially after fracture across all ADL domains assessed

In adjusted analyses:

The greatest decreases in survival after fx occurred with:

- Age older than 90 yoa
- Non-operative fx management
- And advanced comorbidities

(All analyses with statistically significant hazard ratios)

Protect from Injury

The background of the slide features a blue gradient. On the left side, there are black silhouettes of a person in a long-sleeved coat, likely a healthcare professional, standing and touching the shoulder of a person sitting in a wheelchair. The person in the wheelchair is facing right, and the healthcare professional is also facing right, looking towards the patient.

Protecting Patients
from Harm:
Our Moral Imperative

Morse Fall Scale(Morse, 1997, *Preventing patient falls.*)

Morse Fall Scale		
Risk Factor	Scale	Score
History of Falls	Yes	25
	No	0
Secondary Diagnosis	Yes	15
	No	0
Ambulatory Aid	Furniture	30
	Crutches / Cane /	15
	None / Bed Rest / Wheelchair	0
IV Therapy / Heparin Lock	Yes	20
	No	0
Gait (Transferring) <i>*If the patient is in a w/c, this is scored based on the gait the patient uses to transfer</i>	Impaired	20
	Weak	10
	Normal/ Bed Rest / Immobile	0
Mental Status	Forgets Limitations	15
	Oriented to Own Ability	0

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

Screening to Assessment

- History of Falls
 - Screen: yes or no
 - Assessment: based on positive or negative screen response
- Assessment must be comprehensive
- Required for rest of nursing process

Interventions

1. Basic preventive and **universal falls precautions** for *all patients*
2. **Assessment** of *all patients* for risk of falling **and sustaining injuries** from a fall in the hospital
3. **Cultural** infrastructure
4. Hospital protocols for those identified at risk of falling
5. Enhanced **communication** of risk of injury from a fall
6. **Customized interventions** for those identified at **risk of injury from a fall**

**Prevent
serious
injurious falls**

The diagram features a central green circle labeled 'AIM' at the top. Below it, three overlapping circles represent strategies: a black circle on the left labeled 'Promote a culture of safety', a grey circle on the right labeled 'Promote the safe use of technology', and a central green circle labeled 'AIM'. A thick blue horizontal bar is positioned above the strategy circles. A white curved line connects the top of the 'AIM' circle to the top of the 'Prevent serious injurious falls' oval. A black curved line connects the top of the 'Promote a culture of safety' circle to the top of the 'Prevent serious injurious falls' oval. A grey curved line connects the top of the 'Promote the safe use of technology' circle to the top of the 'Prevent serious injurious falls' oval. The background includes a green vertical bar on the left and a white background with a blue horizontal bar.

**Promote a
culture of
safety**

AIM

**Promote the
safe use of
technology**

5 Essentials to Protect from 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**

**You can protect patients from
injurious falls**

Injury
Prevention
Interventions

Interventions
specific to
Injury Risk

Injury Risk
Assessment

What
to Put
in
Place

Resources:

<http://www.visn8.va.gov>

[/patientsafetycenter/fallsTeam/default.asp](http://www.visn8.va.gov/patientsafetycenter/fallsTeam/default.asp)

Creating Safe Environment

Reduce Blunt Force Trauma

Try to eliminate sharp edges

Decrease impact from falls

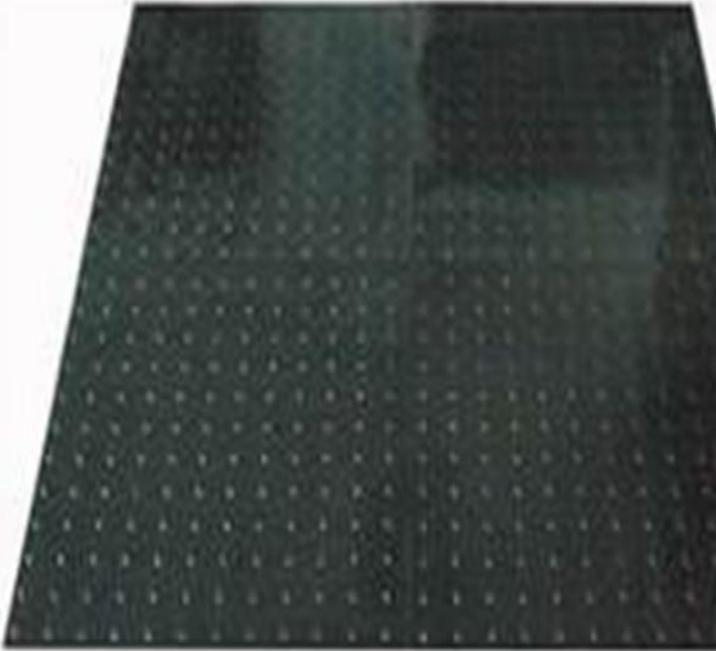
Ensure Safe Bathrooms! Why?

Make Toilet Safer





Rubberized Flooring



Eliminate Sha

- KidCo
- KidSafe

Search:

- Furniture

Corner Cushions



Bedside Mats – Fall Cushions



bedside fall cushion



Traditional Floor Mat



Floor Cushion



Tri-fold bedside mat



Roll-on bedside mat



Soft Fall bedside mat

Summary of Results

Feet First Fall from Bed

No Floor Mat fall over top of bedrails: ~40% chance of severe head injury

No Floor Mat, low bed (No Bedrails): ~25% chance of severe head injury

Low bed with a Floor Mat: ~ 1% chance of severe head injury

Technology Resource Guide: Bedside Floor Mats



- Bedside floor mats protect patients from injuries associated with bed-related falls.
- Targeted for VA providers, this web-based guidebook will include: searchable inventory, evaluation of selected features, and cost.

Hip Protector Toolkit



This web-based toolkit will include:

- prescribing guidelines
- standardized CPRS orders
- selection of brands and models
- sizing guidelines
- protocol for replacement
- policy template
- laundering procedure
- stocking procedure
- monitoring tools
- patient education materials
- provider education materials

Hip Protectors



Best Practice Patient Education Brochure *“Anticoagulation: Preventing Injurious Falls”*

Risk for falls

Practical strategies to prevent injuries

Actions to take if one falls

Fall prevention strategies



What to do
When you
Fall...



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Patient
Safety
Center
Tampa, FL

What to do When you Fall...

Moderate to Serious Injury

- Those that limit function, independence, survival
- **A**ge
- **B**ones (fractures)
- **A**nti**C**oagulation (hemorrhagic injury)
- **S**urgery (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)

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

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

Fall Prevention and Injury Reduction Matrix

(Assumes Universal Falls Prevention Implemented)

RISK OF FALL +	+ RISK FALL/-- RISK INJURY Implement fall reduction interventions Assess, intervene and communicate if <u><i>injury risk</i></u> changes	+ RISK FALL/+ RISK INJURY Implement fall reduction interventions Implement injury prevention interventions Assess, intervene and communicate if <u><i>fall risk or injury risk</i></u> changes
	--RISK FALL/--RISK INJURY Assess, intervene and communicate if <u><i>fall risk or injury risk</i></u> changes	--RISK FALL/+RISK OF INJURY Implement injury prevention interventions Assess, intervene and communicate if <u><i>fall risk</i></u> changes
-	RISK OF INJURY FROM A FALL	

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

Bones/Fracture Risk and/or History

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

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

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

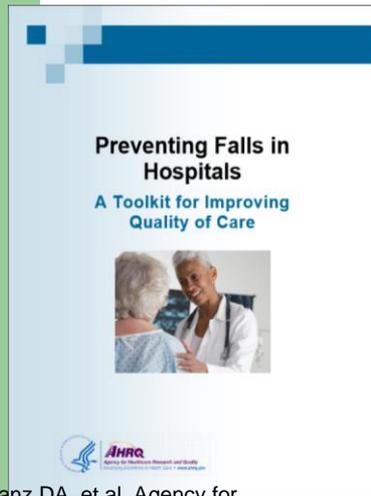
Toolkits and Best Practice Recommendations for Fall Prevention

AHRQ Falls Prevention Toolkit

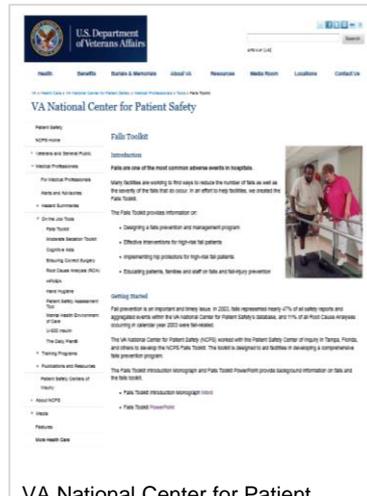
VA NCPS Falls Toolkit

ICSI Prevention of Falls Protocol

IHI Reducing Patient Injuries from Falls How-to Guide



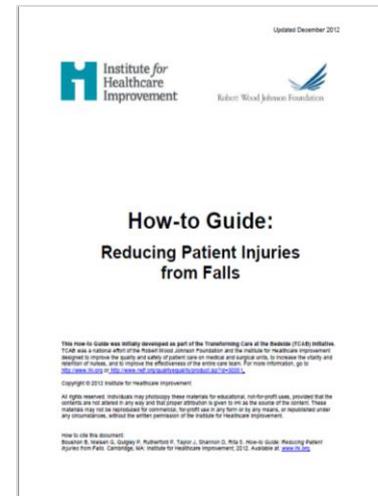
Ganz DA, et al. Agency for Healthcare Research and Quality. 2013.



VA National Center for Patient Safety (NCPS). 2014.



Degelau J, et al. Institute for Clinical Systems Improvement (ICSI). 2012.



Boushon B, et al. Institute for Healthcare Improvement. 2008.

Shifting

- From Reducing Falls to Protecting from Fall Related Injury
- Integrate Injury Risk /History on Admission
- Implement Universal Injury Reduction Strategies
- Implement Population-Specific Fall Injury Reduction Interventions

Suggestions from TJC

- 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, **assess fall 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

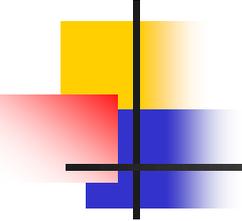
Suggestions con't

- 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.

Discussion – Questions?

- I hope this helps!
- pquigley1 @tampabay.rr.com



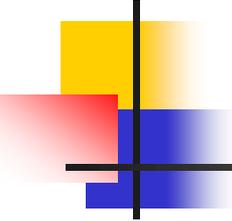


Post Fall Management: Is your program working?

Pat Quigley, PhD, MPH, APRN,
CRRN, FAAN, FAANP
Nurse Consultant

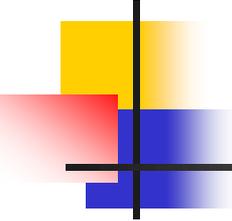
pquigley1@tampabay.rr.com





Objectives

- Profile severity of injury associated with falls, with focus on hip fractures and head injury
- Discuss essential steps to integrate injury prevention into practice
- Explain protective nature of hip protectors, helmets and floor mats
- Explore strategies to reduce barriers to implementation and adoption

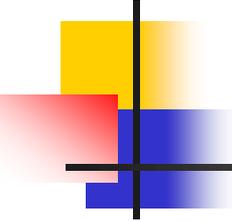


My Goals

- **Challenge** and **Inspire** you to add **precision** to your patient safety practices and redesign fall prevention clinical practices to protect patients from **Injurious Falls** as your organization's **Primary Outcome**

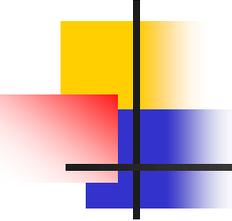
Falls at Bedside





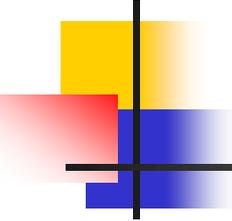
Objectives

- Examine post fall practices as key intervention to reduce repeat falls
- Differentiate:
 - Post Fall Huddles
 - Post Fall Management
 - Post Fall Documentation
 - Incident Report



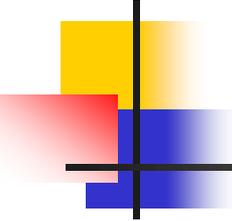
Let's Share!

- How do you know your fall prevention program is working?
- Can you affirm that patients who fall more than once are not falling for the same reason?
- How is your post fall program working?
- How do you measure success?



Post Fall Practices

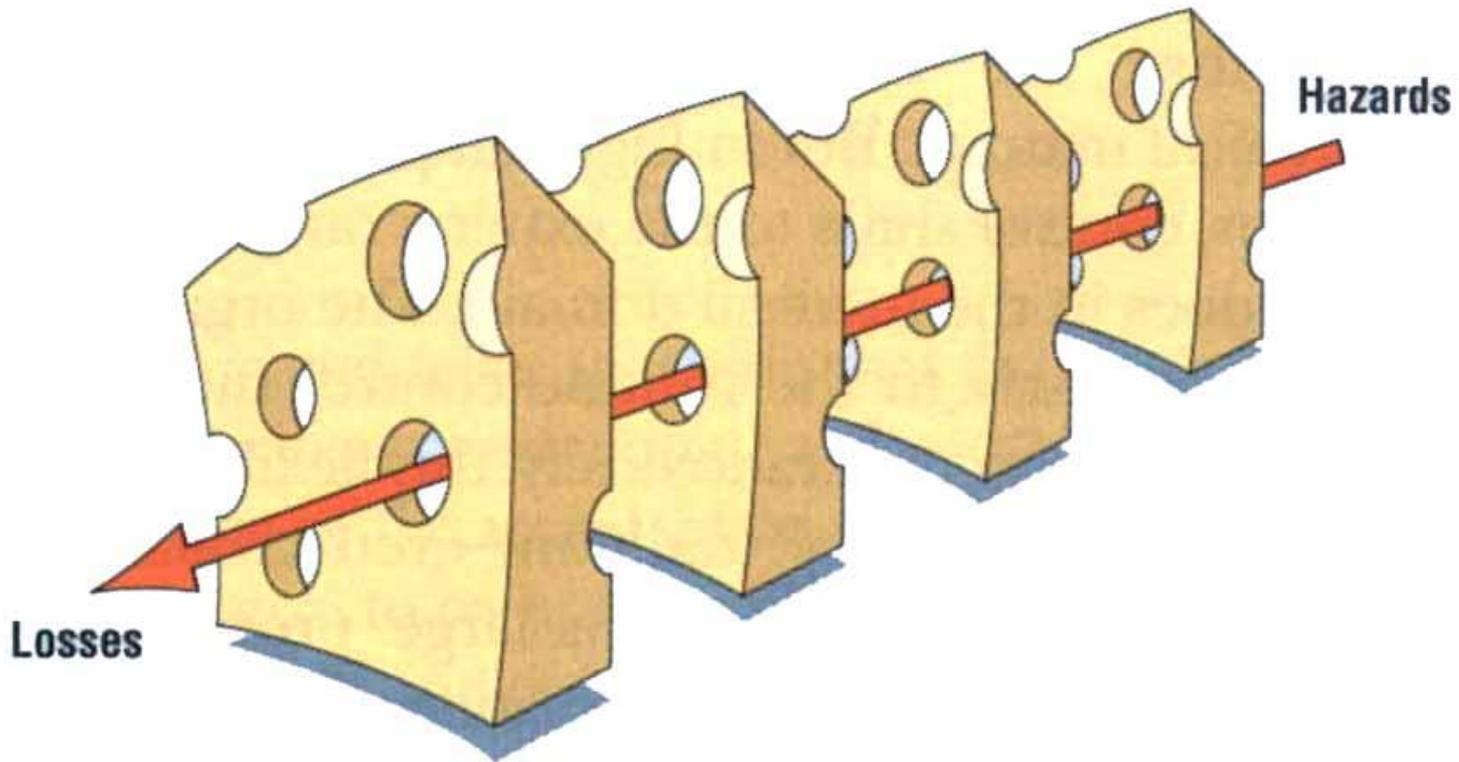
- Post Fall Huddle
- Post Fall Assessment
- Patient/Resident/Family Education
- Staff Education

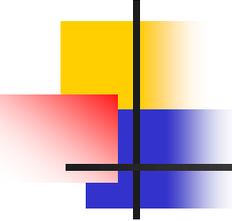


Safety Huddles

- **Pre-Shift Huddles**
- **Post Fall Huddles**
- Conducted with the patient/resident where the fall occurred within 15 minutes of the fall
- Post Fall Analysis
 - What was different this time?
 - When
 - How
 - Why
 - Prevention: Protective Action Steps to Redesign the Plan of Care
- **Post Fall Debriefing Huddle**

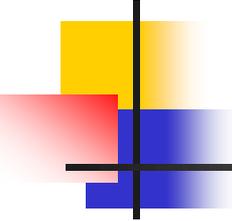
Accident Theory





Post Fall Huddle (PFH): Essential Components

- A brief staff gathering, interdisciplinary when possible, that immediately follows a fall event.
- Convenes within 15 minutes of the fall event
- Clinician(s) responsible for patient/resident during fall event leads the PFH
- Involves the patient/resident whenever possible in the environment where the patient/resident fell
- Requires Group Think to discover what happened.
- Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient/resident fell.
- Guiding question to ask: **What was different this time you were doing this activity, compared to all the other times you performed the same activity (and did not fall), but this time you fell?**

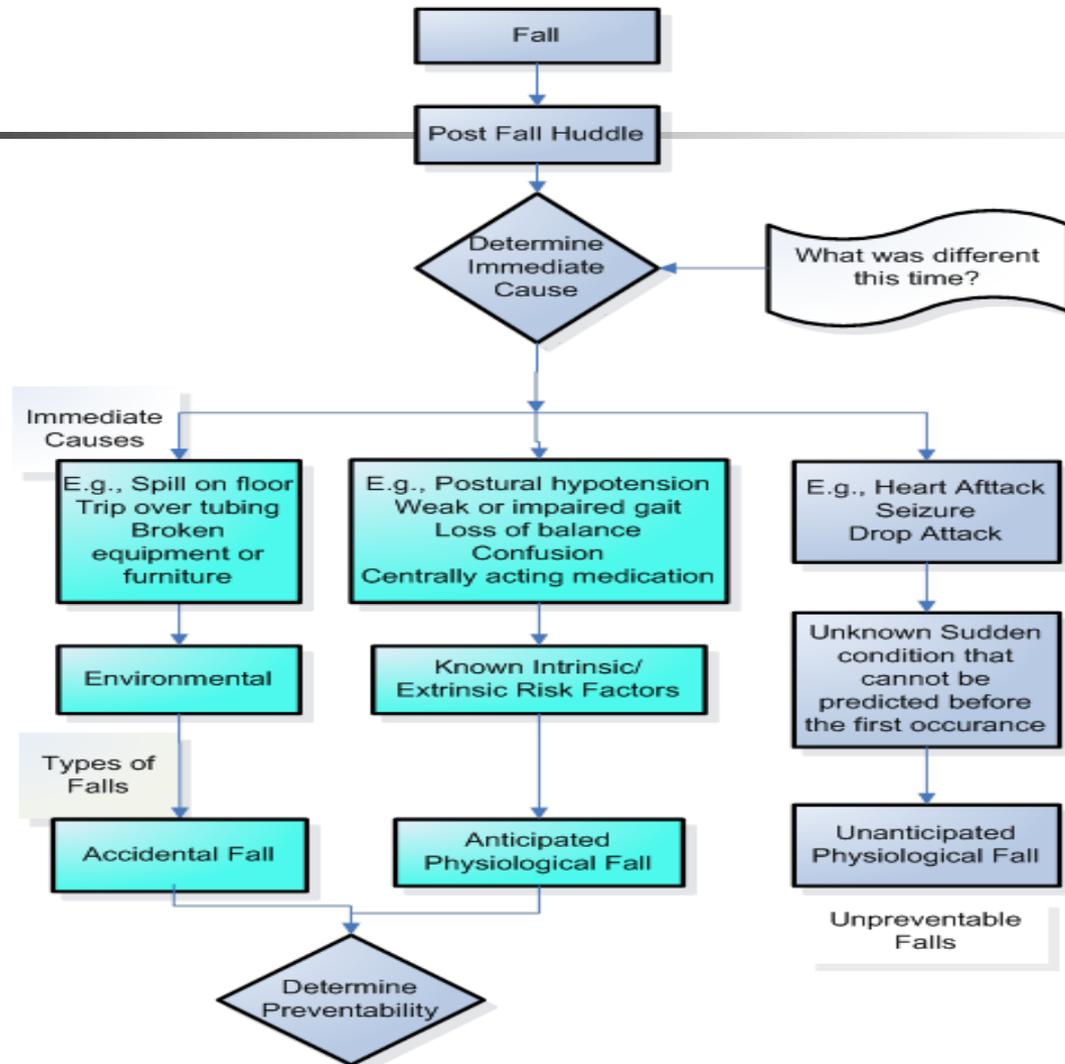


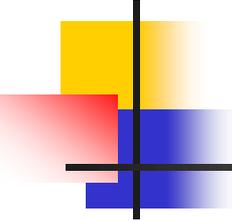
Steps to the Post Fall Huddle

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 fall, injury and 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

Decision Tree for Types of Falls

Tuesday, April 22, 2014





Determine Preventability

Step 1: Conduct the Post Fall Huddle.

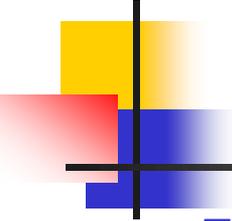
Step 2: Determine the Immediate Cause of the Fall.

Step 3: Determine the Type of Fall.

Step 4. If Accidental and Anticipated Physiological Falls, determine Preventability:

Could the care provider (direct care provider) have anticipated this event with the information available at the time?

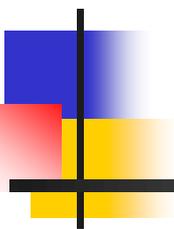
- *If the Answer is **NO**, the fall is Not preventable.*
- *If the answer is **YES**, the provider must ask another question: Were appropriate precautions taken to prevent this event?*
- *Answer:*
 - *No, Clearly or likely Preventable;*
 - *Yes, Clearly or likely Unpreventable*



Outcomes of Post Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient / Resident (family) involved in learning about the fall occurrence
- Prevent Repeat Fall
- Reduce Repeat Fall Rate

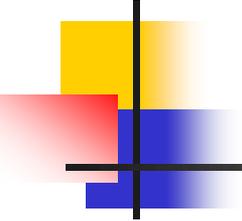
Post Fall Huddle Resources



VA: Falls Toolkit
Post Fall Huddles

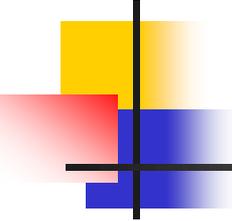
www.patientsafety.va.gov

AHRQ Falls Toolkit 2013



Tools

- Post Fall Huddle Process
- Decision Tree
- Post Fall Huddle Form
- Determine Preventability
- Case Study Exercises



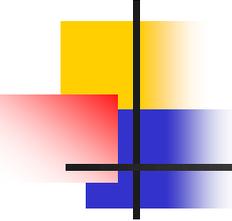
Formative Measures

- Structures:

- Who attends: Nursing and others – Count them
- Changed Plan of Care: Add actions to your run-chart: Annotated run chart; Capture interventions

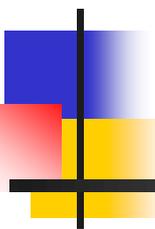
- Processes:

- Timeliness of Post Fall Huddle (number of minutes)
- Timeliness of changing plan of care
- Time to implemented changed plan of care



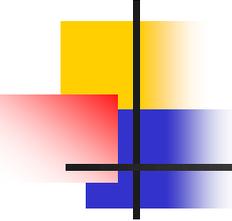
Summative Outcome

- Prevent Repeat Fall: Same Root Cause and Same Type of Fall
- Reduce costs associated with falls and fall related injuries



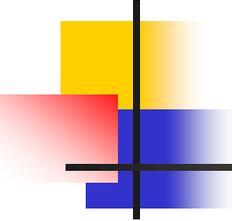
Post Fall Assessment

Different than a Huddle!



Post Fall Assessment

- In-depth Data Gathering
- Circumstances of the Fall
- Patient/Resident Presentation
- Assessment of Patient/Resident Condition



Comprehensive Post-Fall Assessment

Includes:

- General information about the fall
- Subjective & objective falls documentation
- Patient/Resident Assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based on Fall Risk Scale/ Morse falls scale
- Facility personnel and family notification

Post-Fall Assessment: History: Review of Systems

- Patient Symptoms to Elicit on History Linked to Risk Factors

Symptom	Fall Risk Factor
Visual disturbance (double vision, blurry vision, loss of vision)	Visual impairment?
Dizziness/lightheadedness	Orthostatic hypotension? Abnormal vital signs?
Leg weakness	Gait or balance instability?
Urinary urgency or frequency	Urinary incontinence?
Syncope/loss of consciousness	One or more chronic diseases

Post Fall Note (EMR)

GENERAL INFORMATION ON FALL

Age: 108

Gender: MALE

Date/Time of Fall: *

Has patient already fallen today? * Yes. No. Unknown.

Location of Fall:

- Patient/Resident Room
- Patient/Resident Bathroom
- Shared Bathroom
- Hallway
- Patient/Resident Lounge
- A Non-Nursing Department -

If non-nursing department, can type in location of fall

Fall Witnessed:

- No
- Yes

Fall Witnessed – Yes or No (i.e. no other choices or drop-downs)

Gen Info

GENERAL INFORMATION ON FALL

Age: 108

Gender: MALE

Date/Time of Fall: *

Has patient already fallen today? * Yes. No. Unknown.

Location of Fall:

- Patient/Resident Room
- Patient/Resident Bathroom
- Shared Bathroom
- Hallway
- Patient/Resident Lounge
- A Non-Nursing Department -

Fall Witnessed:

- No
- Yes

Patient/Resident Assisted to Minimize Fall:

- No
- Yes

Category of Person Who Minimized Fall:

RN
LVN/LPN
NA/UAP
Other Professional Staff
Sitter
Another Patient
Visitor
Other:

If pt/resident assisted to minimize fall – these are answer options for 'Yes' selection; added PT, OT

Patient/Resident Restrained at Time of Fall:

No

Yes Comment:

Limb Restraints

Vest Restraints

Side Rail Restraints

Blanket Restraints

Mittens

Locked Leather Restraints

Other Restraints: *

Options if 'Yes'
selected for
pt/resident
restrained at time
of fall'

PATIENT/RESIDENT DESCRIPTION OF THE FALL

Patient/Resident's Statement of What Occurred:

*

Text boxes for
pt/resident
description of what
occurred, as well as
nursing description
of pt/resident &
environment at
time of fall

PATIENT/RESIDENT ASSESSMENT POST FALL

Nursing Observations:

(Please describe your observations of the patient and
of the environment when arriving on the scene.)

Patient/Resident:

*

PATIENT/RESIDENT ASSESSMENT POST FALL

Nursing Observations:

(Please describe your observations of the patient and of the environment when arriving on the scene.)

Patient/Resident:

*

Environment:

*

Vital Signs (Pulse/Blood Pressure)

Routine VS (If unable to take orthostatic VS)

Pulse:

Blood Pressure:

Respirations:

Enter routine
Vital Signs (VS)
if unable to take
orthostatic VS

Environment:

*

Vital Signs (Pulse/Blood Pressure)

Routine VS (If unable to take orthostatic VS)

Pulse:

Blood Pressure:

Orthostatic VS (If patient condition permits)

Take BP/P in two positions:

Lying --> Standing

OR

Lying --> Sitting (if patient is unable to stand or becomes symptomatic when sitting).

Initial: Lying: (Have patient lie flat for two to five minutes before taking lying VS)

Pulse:

Blood Pressure:

Immediate Change in Position:

(Take BP/P upon immediate change in positions, lying to standing or lying to sitting)

Standing:

Pulse:

Blood Pressure:

Sitting: (If unable to stand)

Pulse:

Blood Pressure:

Unable to take due to fact that patient/resident can't tolerate upright position

Clicking on 'orthostatic VS' opens instructions and ability to document vitals

Reminder Dialog Template: NURSING POST FALL ASSESSMENT (595-DT-336)

(Ref: Initial orthostatic hypotension is characterized by a BP decrease of more than 40 mm Hg immediately on standing. BP then spontaneously and rapidly returns to normal so that the period of hypotension and symptoms is short. Classic orthostatic hypotension is characterized by a decrease in SBP of 20 mm Hg or greater and in diastolic BP of 10 mm Hg or greater within 3 minutes of standing. (Cronin and Kenny, 2010. Cardiac causes of falls. Clinics in Geriatric Medicine))

Repeat standing or sitting

(Take BP/P three minutes after immediate position change)

Standing:

Pulse:

Blood Pressure:

Sitting: (If unable to stand)

Pulse:

Blood Pressure:

Unable to take due to fact that patient/resident can't tolerate upright position

Orthostatic BP
Reference/instructions

Glucometer Reading

Is patient/resident diabetic?

(If not diabetic but reading was taken, you may enter)

No

Yes

Glucometer Reading *

Is Patient/Resident Hypoglycemic? (blood glucose level equal to or below 70 mg/dl)

No

Yes

Visible Signs of Injury:

- No
- Yes (Select all that apply)

Swelling:

Location: (Select all that apply)

- Torso - Front
- Torso - Back
- Head
- Neck
- Shoulder - Right
- Shoulder - Left
- Arm - Right
- Arm - Left
- Elbow - Right
- Elbow - Left
- Wrist - Right
- Wrist - Left
- Hand - Right
- Hand - Left
- Hip - Right
- Hip - Left
- Knee - Right
- Knee - Left
- Leg - Right
- Leg - Left
- Foot - Right
- Foot - Left

If yes to visible signs of injury, type of injury can be selected (e.g. deformity); selection prompts nurse to select location on pt/resident body

Visible Signs of Injury:

No

Yes (Select all that apply)

Swelling:

Laceration(s):

Abrasion(s):

Deformity(ies):

Other:*

New Pain:

Unable to verbalize

No

Yes

Change in Range of Motion (ROM):

Unable to test due to pain

No

Yes

Physical assessment – New Pain or Change in Range of Motion – If selection is 'Unable to Verbalize' or 'No', can go on to next question (includes list of locations, including other as comment with pain rating)

New Pain:

- Unable to verbalize
- No
- Yes

Location: (Select all that apply)

- | | | |
|---|----------------|----------------------|
| <input type="checkbox"/> Torso - Front | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Torso - Back | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Head | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Neck | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Shoulder - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Shoulder - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Arm - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Arm - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Elbow - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Elbow - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Hand - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Hand - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Hip - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Hip - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Knee - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Knee - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Foot - Right | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Foot - Left | Pain Rating: * | <input type="text"/> |
| <input type="checkbox"/> Other: * | | <input type="text"/> |
| | Pain Rating: * | <input type="text"/> |

New Pain – if yes, can select location and pain rating for that location (1-10) scale

Change in Range of Motion (ROM):

Unable to test due to pain

No

Yes

New decreased range of motion right upper extremity.

New decreased range of motion left upper extremity.

New decreased range of motion right lower extremity.

New decreased range of motion left lower extremity.

New decreased range of motion back.
.....

New decreased range of motion neck.

Change in ROM:
if yes, select
body area
involved –

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

If no suspected or actual
head impact, select 'no'
and move on

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

If Suspected or actual impact to head: 'Yes' selection opens Glasgow Coma scale and guidance

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: *

Best Verbal Response: *

Best Motor Response: *

Total Score (Select the correct Glasgow Coma Scale Score)

- Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)
- Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)
- Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)

Adding up the Eye, Verbal, and Motor scores correlates with mild, mod, or severe brain injury

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: *

Best Verbal Response: *

Best Motor Response: *

Total Score (Select the correct)

Glasgow Coma Scale Score 13-15 (Correlates with mild brain injury)

Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)

Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)

Scoring options for Best Eye Response

- 1 = No eye opening
- 2 = Eye opening to pain
- 3 = Eye opening to verbal command
- 4 = Eyes open spontaneously

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)

Best Eye Response: *

Best Verbal Response: *

Best Motor Response: *

Total Score (Select the correct

Glasgow Coma Scale Score

Glasgow Coma Scale Score

Glasgow Coma Scale Score

1 = No verbal response

2 = Incomprehensible sounds

3 = Inappropriate words

4 = Confused

5 = Oriented

6 = Intubated

Scoring options for
Best Verbal
Response

(in injury)

(brain injury)

(severe brain injury)

NEUROLOGICAL ASSESSMENT

Patient/Resident has a suspected or actual impact to the head.

No

Yes

Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

(The score is often expressed as a sum of individual components: E4 + V5 + M6 = 15)

Best Eye Response: *

Best Verbal Response: *

Best Motor Response: *

Total Score (Select the correct score)

Glasgow Coma Scale Score

Glasgow Coma Scale Score

Glasgow Coma Scale Score

- 1 = No motor response
- 2 = Extension to pain
- 3 = Flexion with pain
- 4 = Withdrawal from pain
- 5 = Localizing pain
- 6 = Obeys commands

Best Motor Response

Pupils

Size

- Equal
- Right greater than Left
- Left greater than Right.

Pupils as part of neurological assessment

Reactivity

- Right eye reactive to light
- Right eye not reactive to light
- Left eye reactive to light
- Left eye not reactive to light

Prior score pulled in from Mental Health Pkg for the last time pt/resident had a Morse Fall Scale done (or will say 'no data available')

Follow your facility policy for continuing neurological checks.

PREVIOUS MORSE FALL SCALE INFORMATION

Date	Instrument	Raw	Trans	Scale
12/08/2011 14:10	MORSE FALL SCALE	0		Morse Score

Guidance for use of Morse Fall Scale

Information on Morse Fall Scale (click to open)

- Patient/Resident forgets limitations (Mental Status Assessment) - (positive response to Morse Fall Scale Question #6)

choose at least one

- Re-educate/reminders regarding safety
- Move closer to Nurses' Station
- Provide clocks and calendars
- Use a wandering monitoring device
- Arrange for diversional activities
- Observe every one hour
- Other:

- Other Fall Prevention Interventions (based on clinical judgment)

*

INJURY PREVENTION INTERVENTIONS

Injury Prevention Interventions:

Select all that apply

- Injury Prevention:
- Height adjustable bed (low position when resting in bed)
- Hip protectors
- Floor mat
- Helmet
- Patient Education about anticoagulation and fall occurrence

INJURY PREVENTION INTERVENTIONS

Preventive
intervention
selections

Injury Prevention Interventions:

Select all that apply

Injury Prevention:

- Height adjustable bed (low position when resting in bed)
- Hip protectors
- Floor mat
- Helmet
- Patient Education about anticoagulation and fall occurrence
- Other:

NOTIFICATIONS

Physician Notified:

Time of notification:

Name of physician notified:

Nursing Administrator/Nursing Supervisor Notified:

Time of notification:

Name of administrator/supervisor notified:

Family Notified:

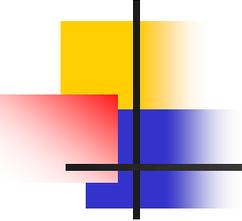
Family notified by nursing staff
Time of notification:
Name of family member/support person notified:

- MD responsible for notification
- No family members/support person listed
- Unable to reach family
- Other

Nursing Staff Notified (that the patient/resident has fallen and is at risk to fall again):

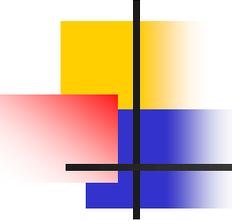
Time of notification:

Other Corrective Actions Taken Post Fall:



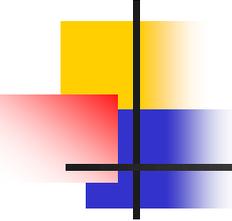
Teaching: After a Fall

- Reframe patient/resident 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?



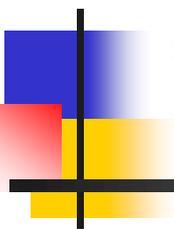
Staff Education

- Universal Fall Prevention
- Individualized Fall Prevention
- Injury Reduction Strategies
- Root Cause Trends of Falls
- Interventions for Improvement
- Impact of Changes in Practices



You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com



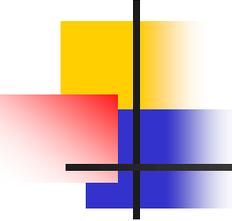
Patient Engagement: Changing the Conversation

Patricia A. Quigley, PhD, MPH, ARNP, CRRN,
FAAN, FAANP

Nurse Consultant

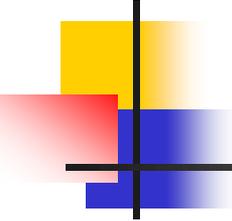
Former Associate Director, VISN 8 Patient Safety
Center of Inquiry, Department of Veterans Affairs

Former, Associate Chief, Nursing Service for
Research, James A. Haley Veterans Hospital,
Tampa, Fl.



Objectives:

- Redesigned education strategies critical to ensuring that patients have the knowledge and skills to maximize their health, well-being, functional independence and social integration.
- Revitalize your role to teach, reinforce and evaluate effective education to promote positive patient outcomes.
- Focus on health literacy as the foundation to increase the probability that patients really learn what they need to as a result of education programs.
- Refresh their knowledge of the domains of learning, health literacy, and tools to examine teaching effectiveness.

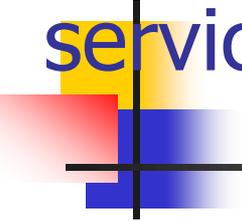


Changing US Population Profile

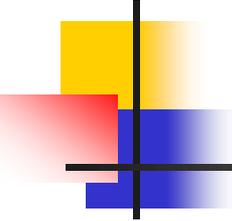
- Hundreds of languages are spoken or signed
- In some cities, < than 60% of the population has English as a first language
- Hispanic/Latino and Asian American populations are growing at dramatic rates
- By 2025, almost 40% of Americans and about half of all US children are projected to be members of minority population

NIH: <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy> (updated 072916)

Anyone who needs health information and services also needs health literacy to:

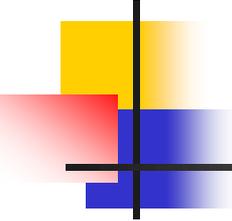


- Find information and services
- Communicate their needs and preferences and respond to information and services
- Process the meaning and usefulness of the information and services
- Understand the choices, consequences and context of the information and services
- Decide which information and services match their needs and preferences so they can act



People with Literacy Problems

- Found among all ethnicities, races and classes
- A link exists between literacy and education and income levels
- Many of the same populations at risk for limited health literacy also suffer from disparities in health status, illness (i.e., heart disease, diabetes, obesity, etc.) and death



Health Literacy Defined

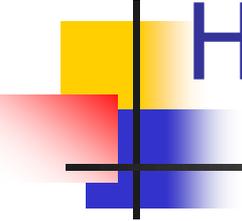
- The degree to which individuals have the capacity to obtain, process, and understand basic health information and access services needed to make appropriate health decisions.

Source: Healthy People 2010

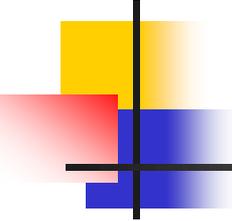
“Saves Lives. Saves Time. Saves Money.” NIH

<https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy>

Negative Outcomes Associated with Health Literacy

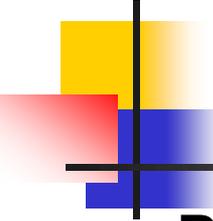


- Misunderstandings
- Medical Errors
- Unnecessary Hospitalization
- Extended Hospital Stays
- Medical Non-adherence
- Delayed onset of healthcare
- Limitations with Self-care management



Capacity and Skill

- Capacity is the potential a person has to do or accomplish something.
- Health literacy skills are those people use to realize their potential in health situations.
- They apply these skills either to make sense of health information and services or provide health information and services to others.
- Health Literacy:
www.cdc.gov/healthliteracy/learn/index.html



Health Literacy Tools

- **REALM***

- Rapid Estimate of Adult Literacy in Medicine

- **TOFHLA***

- Test of Functional Health Literacy in Adults

- **BRIEF**

- Single Screening Items

**Long and Short Form Available*

- **NVS***

- Newest Vital Sign

- **Meter**

- Medical Term Recognition Test

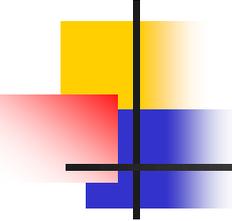
- **SAHLSA-50**

- Short Assessment of Health Literacy for Spanish Adults

AHRQ Health Literacy Universal Precautions Toolkit 2nd Edition:
<https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>

Domains of Learning





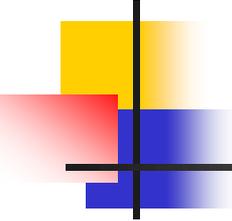
Since 1956....

- Cognitive Domain
- Psychomotor Skills Domain
- Affective Domain

Refer to: University of Dayton School of Law:

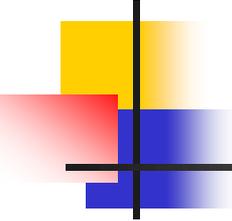
<http://academic.udayton.edu/health/syllabi/health/Unit01/lesson01b.htm>

Bloom Benjamin S. and David R. Krathwohl. Taxonomy of Educational Objectives: The Classification of Educational Goals, by a committee of college and university examiners. Handbook I: Cognitive Domain. New York, Longmans, Green, 1956.



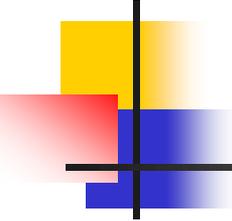
Cognitive Domain (Knowledge)

- Content knowledge
- Development of intellectual skills.
- Recall or recognition of specific facts and concepts that serve developing intellectual abilities and skills.
- Six major categories, starting from the simplest behavior (recalling facts) to the most complex (Evaluation) (Bloom's Taxonomy)



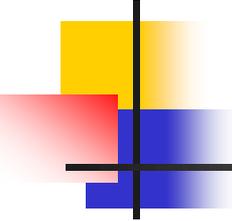
Methods to Evaluation Learning

- Teach Back: Tell You Back
- Post Test



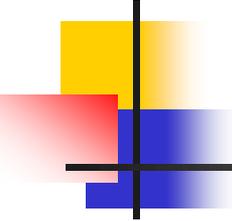
Psychomotor Domain (Skills)

- Physical movement
- Coordination
- Use of the motor-skill areas.
- Development of these skills requires practice
- They are measured in terms of speed, precision, distance, procedures, or techniques in execution



Method to Evaluate Learning

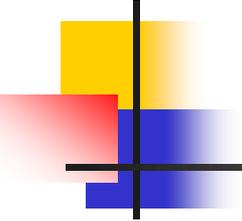
- Show you back
- Return Demonstration



Affective Domain (Attitude)

- Feelings
- Values
- Appreciation
- Enthusiasms
- Motivations
- Attitudes

Partnership

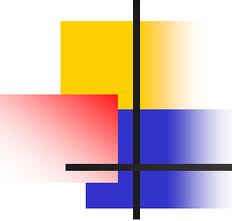


■ Patients

- 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

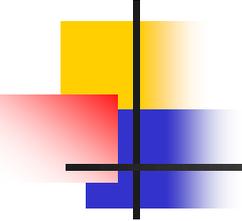
■ Family

- Partners in Care – Advocates, Information Gatherers
- Messengers
- Provide ongoing assessment in the home
- Teach clinicians about their safe practices



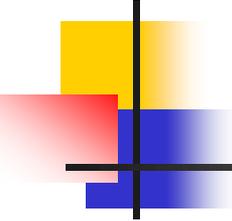
Changing Your Conversation with Patients

- 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?



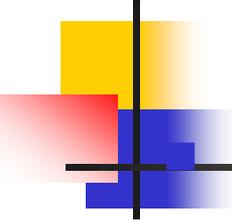
Autonomy

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



Patient Education is Not One Way Communication

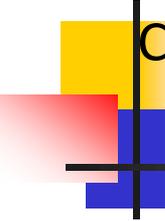
- Think Systems Theory
- Teaching Individualized Fall Risk Factors
- A Simple Example: **Blood Thinners – What to do if you fall?**



“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”.



“I want to be sure I explained everything clearly.

Can you please explain it back to me so I can be sure I did?”

Teach Back Question Card #1

We covered a lot today about preventing falls, and I want to make sure that I explained things clearly. So let's review what we discussed.

What are three strategies that will help you prevent falls?”

Teach Back Question Card #3

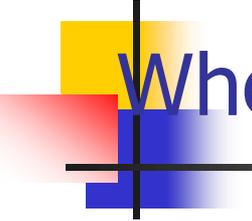
“I want to make sure I explained this clearly. When you get back home in a few days, what will you tell your *[friend or family member]* about *[key point just discussed]*?”

Teach Back Question Card #2

“I want to be sure that I did a good job of teaching you today about risk for falls.

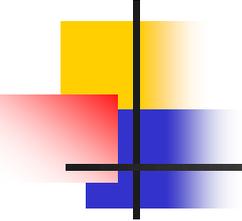
Could you please tell me in your own words what you are doing to prevent falls? How you will prevent falls in the future?”

Teach Back Question Card #4



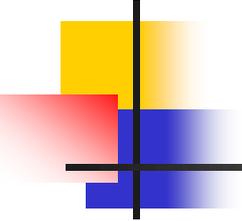
When “Teach Back” Is Especially Important:

- 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 do to stay safe from falling in the hospital?
 - Why it is important for the patient to do this?

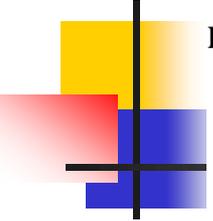


Using Teach Back to Redesign Patient Teaching: Fall Prevention and Injury Protection

—First 24 hours of Admission:

Use Teach Back with patients to improve understanding of for Cognitively alert patients

- **The top 3 reasons you are at risk for falling and/or injury**
(Based on your fall risk assessment and history of injury risk)
- **The 3 main reasons fall prevention is important**
 - Falls for the most part are preventable
 - Falls can result in injury
 - Falls can make your hospital stay longer
- **Three actions you can take to stay safe**
 - Learn about your fall risk factors
 - Call first for help (using the call light)
 - a. Wait for help before you get out of bed or up from a chair



4. **Two important safety reasons why you need to ask for help when needing to go to the bathroom**

- The hospital bathroom is not like yours at home, and unfamiliar places can increase your risk of falling.
- Bathrooms are unsafe areas because they are small and it is easy to lose your balance or become dizzy.

5. **The main purpose for you to use the call light**

- To call the nursing staff for help.
 - Let's find where your call light is – at your bedside and in the bathroom
 - Demonstrate use of the call light at both the bedside and the bathroom
-
- **The main reason we want you to wear your non-slip footwear?**
 - To prevent feet from slipping on the floor, which can increase your fall risk.

Other content areas:

- **Choosing Not to Call for Help**
 - What happens if you experience an accident and that accident is a fall?
 - You could get injured
 - Your length of stay may be increased
 - You may not be able to go home when you planned

Knowledge Test After and Return Demonstration Checklist:

Total Score: 15 points

Question 1

• What are the top 3 reasons you are at risk for falling and/or injury?
(Based on your fall risk assessment and history of injury risk)

- _____
- _____
- _____

Answer: 3/3

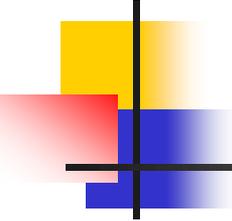
• What are the 3 main safety reasons fall prevention is important?

Answers:

- Falls for the most part are preventable
- Falls can result in injury
- Falls can make your hospital stay longer

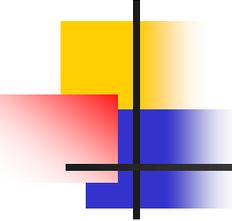
- _____
- _____
- _____

Answer: 3/3



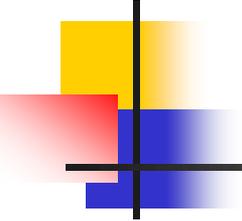
What About Those With Cognitive Impairment?

- They care learn!
- Requires Continuity of Teaching and Repetition:
- Two types of learning:
 - Declarative (Meaning)
 - Procedural (Sequential Tasks)



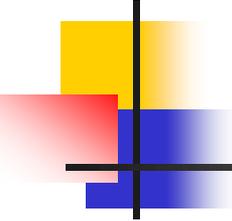
Evaluating Your Teaching

- A one time test of knowledge - is that enough?
- Do you teach a diabetic patient how to manage diabetes one time?
- Isn't fall risk management complex?
- Why did we start using "non-compliance?"
- I can teach a Stroke Patient how to safely transfer – Why? But how you teach a right brain CVA is different than a left brain CVA
 - Right???



Teaching: After a Fall

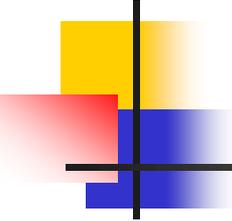
- Reframe patient education curricula to include "what happens after a fall".
- What can we learn from this event?
- How can we work together to prevent this again?



Patient Perceptions about Falls

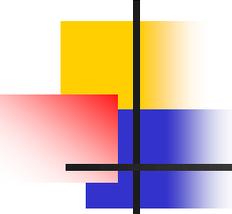
- Lim, Aug, Teo, et al. (2018) acknowledged that efforts to reduce falls are limited by insufficient understanding of patients' views about falls and preventive initiatives dictated by healthcare providers.

Lim, M. L., Aug, S.G.M., Teo, K.Y., Wee, Y.H.C., Yee, S. P., & Ang, S.Y. (2018). Patients' experience after a fall and their perceptions of fall prevention. *JNCQ*, 33(1). 46-52



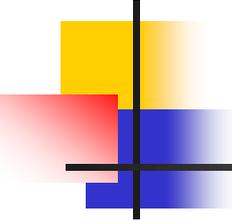
Learning from Fallers

- They studied patients' perspectives toward fall prevention and their experiences about their fall in an acute care hospital in Singapore.
- 100 medically stable and cognitively intact patients were interviewed 1 day after the fall.
- The patients were 64% male, average age of 65.2 years, 94% were alone when they fell, and 58% fell in their room.



6 Themes Emerged

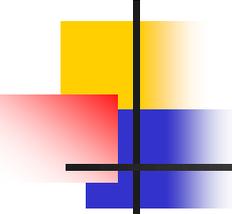
- Apathetic toward falls- falls were not serious and unpreventable
- Self-blame behaviors-described feelings of guilt; admitted to risk-taking behaviors
- Reluctant to impose on busy nurses – did not want to bother the nurses
- Negative feelings toward nurses – frustration with long wait times for nurses to respond
- Overestimated their own ability- to walk independently or manage their activities of daily living
- Poor retention of information – forgot to call and failed to retain fall prevention advice



Consistency in Results

- The findings of this research are consistent with other research findings about patients' perceptions:
- falls are viewed by patients as not serious and unpredictable,
- patients often downplayed the risks of falls, and
- were reluctant to call for help.

Communication With Patients/Staff About Fall Reduction/Injury Prevention

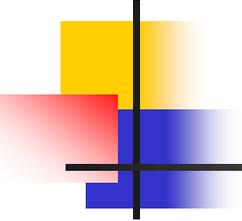


Label or signal patients: known fallers and those at risk of fall or injury

- Use signage/other visual indicators (bracelets, colored socks, special blankets, etc.)

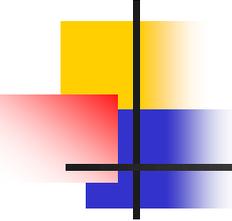
Ensure Safe Handoffs

- Verbalize and repeat-back risk of fall and risk of harm from fall at change of shift
- Verbalize and repeat-back risk of fall and risk of harm from fall between departments



Evaluation of Learning

- Design patient education program evaluation as a knowledge and skills checklist for cognitive and psychomotor domains of learning.
- Include Health Literacy Assessment to check ability to comprehend and use health information

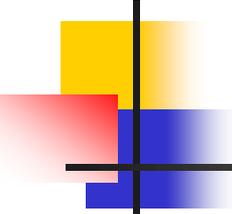


Falls Education Resources

Tool Kits (Usually consist of the following media)

- Web sites
- Videos
- Posters
- Brochures
- Tip Sheets
- Assessments

Patient Educational Materials



- CDC STEADI
 - Staying Independent: Are you at risk? (English)
 - What you can do to prevent falls (English, Spanish, Chinese)
 - Chair Risk Exercise (English, Spanish)
 - Postural Hypotension (English, Spanish)
 - Check for Safety Brochure (English, Spanish)
- VA National Falls Toolkit / VISN 8 PSCI (Patient Safety Center of Inquiry)
 - Hip Protectors (video and brochure; pts and caregivers)
 - Osteoporosis and Men (video)
 - Wall of Education Materials
 - Group Classes – How to fall and how to get up

Falls Education



- CDC (Costs, Hip Fractures, Nursing Homes)

<http://www.cdc.gov/HomeandRecreationalSafety/Falls/pubs.html>



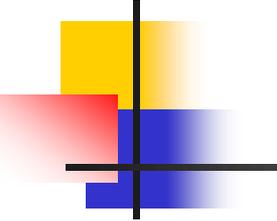
Lighting	Clear Hallways and Stairs	Floors
<ul style="list-style-type: none">• Replace dim, burned out or glaring lights with bright, soft white light bulbs.• Use a night light.• Make sure lights are easy to turn on and off.   <ul style="list-style-type: none">• Keep a flashlight available. 	<ul style="list-style-type: none">• Remove clutter, especially from hallways and stairwells.• Use handrails while taking the stairs.• Place non-skid treads or bright reflective tape to mark the edge of the stairs. 	<ul style="list-style-type: none">• Remove scatterthrow rugs.• Place non-skid treads or double-sided tape under area rugs.• Keep floors free from clutter.• Wipe up spills immediately.• Make sure floors are not slippery.   

- VA (Fall Prevention Tool Kit)

- Provider tools, Patient Education Brochures & Videos

<http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html>



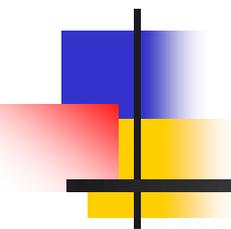


What to do
When you
Fall...



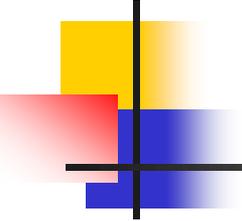
VISN 8
Patient
Safety
Center
Tampa, FL

What to do When you Fall...



To Change Practice is Not for
the Faint of Heart!

But.. You can change your
teaching methods!



I hope this helps!

