Preventing Falls

It's easy to miss what you're not looking for

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Does this sound familiar? Mary, an 87-year-old memory care resident and recurrent faller, has another fall in her room. A housekeeper spots her lying on the floor. Staff rushes to help. The nurse completes an incident report and an intervention is tried. Alarm, floor mat, low bed: what will it be this time?

The same scenario with Mary plays over and over. She falls, a new intervention fails, her family grows concerned, your staff members become frustrated and the facility is at risk.

Ask the Right Questions

Facilities tend to spend a significant amount of time and resources putting interventions in place for residents like Mary before they investigate the root cause of the fall. Why exactly did Mary fall? What was she trying to do right before it happened? How can Mary's falls be prevented?

The first step in root cause analysis is to gather clues, evidence and data about what may have contributed to the fall. Observe the physical environment around Mary and assess her physical and cognitive status.

Next, ask why questions. All staff familiar with Mary, including social service, activities, housekeeping, maintenance and dietary, should be involved in asking the following 10 questions.

1. Ask the resident, are you ok?

2. Ask the resident, what were you trying to do?

3. What was different this time?

4. What was the position of the resident? Did he fall near a bed, toilet or chair? How far? Was she on her back, front, left side, or right side? What was the position of his arms and legs?

5. What was the surrounding area like: noisy, busy, poorly lit, cluttered? If in a bathroom, what are the contents of the toilet? Was there poor visibility? What's the position of furniture and equipment?

6. What was the floor like? Wet? Shiny? Uneven? Carpet or tile? Was there urine on the floor?

7. What was the resident's footwear? Shoes, socks (non-skid), slippers, bare feet?

8. Was the resident using an assistive device, such as a walker, cane, wheelchair, merry walker or another type?

9. Did the resident have glasses and/or hearing aides on?

10.Who was in the area when the resident fell? Any staff, residents or visitors?

THREE CAUSES OF FALLS

- **Extrinsic falls are related to the physical environment: wet floors, excessive noise or placement of furniture.**
- **Intrinsic falls are caused by resident conditions such as orthostatic hypertension, acute infection, pain, sleep deprivation or delirium.**
- **Systemic causes can be related to inconsistent staffing, use of bed alarms, boredom or shift change activity.**

These questions guide staff in conducting the investigation and serve as a tool for the post-fall huddle. Observation skills of staff are a key component in the investigative process. It is easy to miss something you are not looking for. Gather the clues by looking, listening, smelling and touching. Secure the area around the incident including equipment until it has been documented.

A Picture is Worth a Thousand Words

Draw a picture of the fall scene. The drawing should be done by the person finding the resident on the floor. In Mary's case, it would be the housekeeper. Post-fall assessments are based on a comprehensive clinical exam, but often miss key evidence from the fall scene. Mary's exact location, the position of her bed, and placement of her assistive devices are just a few of the clues that can be added to the investigative process from a drawing.

For example, one facility found that the root cause of a fall was that the resident's walker was out of reach. Initially, staff resist drawing a picture of a fall scene, but with additional training and practice, they will acknowledge the value of the additional clues. A study by Empira found that in facilities that combined the drawing with the post-fall assessment, an average of 13 additional clues were identified.

Embracing RCA

One of the initial challenges when conducting RCA is teaching staff how to use critical thinking skills to solve the problem of falls. With the RCA approach, staff are trained, coached and mentored to look for clues. They need to know what questions to ask and must learn critical thinking skills that help them recognize patterns, make predictions and form relationships from the evidence.

The most important level of RCA is a review of systems and processes at the facility level. The

pattern of Mary's recurrent falls should be reviewed by the interdisciplinary team. What time did they occur? Did they occur around shift change? How long since she had been toileted? What meds were given in the last 3 hours? What quality indicators does she flag for? Have other residents had similar falls? Many clues can be found from this data.

Falls related to system factors will continue if RCA is not done facility wide. In one facility, RCA of a monthly fall log indicated that nurses were not identifying and proactively treating pain. When an analysis of the facility's process for orientating nursing staff was reviewed, it was discovered that pain management had been removed from training due to budgetary constraints.

The pattern of falls related to pain had begun shortly after the change in training had been made. The appropriate intervention was to provide pain management training to all nurses and follow up with audits to ensure that both pharmacological and alternative therapies were being used to treat pain proactively. No more falls were reported as a result of unidentified pain in the facility.

Regulatory Issues

Falls pose a risk to resident safety as well as facility liability. F-tag 323 is one of the most frequently cited tags on annual surveys. An appropriate response to residents with recurrent falls will improve quality of care, quality of life, refine systems and processes, and reduce regulatory risk and liability.

CMS' performance improvement framework promotes the use of RCA. The Plan of Correction requires facility to conduct RCA, correct defective actions related to residents, identify others at risk, identify systemic changes, put a plan in place, and monitor to ensure that deficient practices are corrected and sustained.

If RCA is not a key component of a comprehensive fall program, facilities may miss what they are not looking for.

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