Falls – Clinical and Organizational Change Concepts and Ideas

Choose change ideas most appropriate for your LTC home

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ResidentsFirst
Advancing Quality in Ontario Long-Term Care Homes

Recognition and Assessment

Identify potential for improvement.
- Determine baseline measures.
- Identify trends/patterns and barriers.

Assess all residents.
- Assess on admission, change of status and at regular intervals.
- Consider/use:
  – Morse Fall Scale
  – RAI-MDS
- Family member observations as potential source of additional information
- Screen for physical and functional status:
  – Berg Balance Scale
  – Tinetti Gait and Balance Instrument
  – Timed Up and Go
- Screen for osteoporosis (age, low bone mineral density, height loss, history of falls, family fracture history)
- Screen for cognitive impairment (Mini-Mental Status Exam, Confusion Assessment Method Instrument (CAM)
- Screen for visual acuity

Medication review
- Consult with physician and pharmacist regarding medication-related to risk of falls.
- Medication history include identification of medication related falls risk
- Evaluate and manage all residents for polypharmacy and psychotropic medications.

Educate Residents/Family and Staff

Educate residents and families.
- Share risk information with residents and families. Educate and engage family members about prevention strategies.
- Include findings regarding causes of past falls in educational materials.

Educate staff.
- Educate staff at orientation and regular intervals regarding routine practices and protocols and specifics related to interventions for the prevention of falls and injury reduction, risk management, post-falls follow-up, and alternatives to restraints.

Care Planning for Prevention

Care Planning
- Create individualized plan of care with resident, family and staff based on best-practice evidence and assessed risk.
- Medication review and management: manage polypharmacy and psychotropic medications.
- Include falls risk status at transfer of care (shift change, resident rounds and prior to outings).

Document
- Document falls risk assessment results in health record and care plan.

Develop a Communication Plan to support care planning and prevention strategies.
- Communicate risk and prevention strategies (verbal, health record, care plan, shift change, risk rounds, care conferences, programming staff, etc.)
- Develop a handover formal report

Sample Prevention Strategies
- Hip Protectors for high-risk residents
- Maximum use of mobility aids
- Best possible correction of vision and hearing (glasses, hearing aids)
- Hi Lo beds
- Floor mats to cushion falls
- No restraints
- No bed rails
- Toileting routines
- Safe footwear at all times
- Avoid fall-risk related medication (see Recognition and Assessment)
- Strength and balance program
- Use positioning cushions as boundary markers for bed edge.
- Ensure dietary measures: dietary – nutrition and hydration and supplementation (vitamin D and calcium,)
- Manage stimulation (noise, group size)
- Adequate lighting

Improve Work Flow

Consider how to incorporate falls injury prevention strategies into care processes. (See Care Planning)
- Consider care process-related problems that may contribute to falls.
- Communications protocols

Review past falls to identify opportunities for improvement.

Ensure adequate access to supplies and equipment for preventing falls and/or signalling high-risk situations to the multi-disciplinary team.

Establish roles and responsibilities for nurse/ leaders related to effective falls best practices.

Develop Routine Practices

Develop routine practices/checklists to ensure prevention strategies (including medication management) are regularly implemented.
- Regular resident safety checks
- Develop response to fall protocol.
- Checklist for regular environmental safety rounds focussing on falls prevention (e.g. no trip hazards, etc.).

Regularly review causes and risks
- Indentify cause of any previous fall incidents (e.g. falls huddles, root cause analysis) and note if any change to the care plan is required.

Develop policies and procedures that support implementation of best practices and prevention strategies and review regularly (considering post-falls assessments and role and responsibilities of each care provider).
- Review organizational policy for least restraint.

Design Systems to Avoid Mistakes

Clear identification of risk
- Discrete risk identifier
- Chair alarms

Establish workplace culture and environment where staff, families and residents work to support falls prevention.

Develop reminder systems.

Conduct checking and monitoring to ensure prevention measures are implemented effectively
- Environmental safety rounds
- Inspection of mobility aids
- Ensure completion of risk assessments, care processes, fall follow-up and care planning.
- Feedback process about the falls prevention program

Design physical environment to support fall prevention (e.g. furniture arrangement, good lighting, clear exits, floor wax, call bell accessibility, no trip hazards (clutter, slippery floors, etc.) electrical cords)

Falls: Overcoming Barriers Worksheet

Use this table to identify and track your **Change Ideas**. For each **Change Idea**, list all of the **barriers** you can think of, then list all of the **enablers** – or strategies that you could put into place to help overcome the barriers and ensure that your efforts will be effective and successful. Common examples from LTC homes have been included to help get you started.

Change Ideas	**Barriers** – what will get in the way of implementing your idea? (use fishbone and 5 whys to identify)	**Enablers** – what strategies, ideas, tools and tips can you implement that will ensure successful implementation of your change idea
Safe footwear at all times	Family brings unsafe shoes	Put sign in shoe storage area
	Residents forget to wear correct shoes	Visual cues
	Residents thinks safes shoes are unfashionable	Locate sources /provide list of high fashion safe footwear
	Proper footwear is too expensive	Locate sources/provide list of low cost footwear
	Staff unfamiliar with characteristics of unsafe footwear	Visual guide for safe and unsafe footwear
	Shoes don't fit	Contact local shoe store to suggest business opportunity for in-home service
No trip hazards (clutter, slippery floor)	Clutter from resident	Daily clutter checks
	Residents don't recognize "slippery when wet signs"	Use a barrier instead of sign
	Spillage of drinks	No spill cups for selected residents
No restraints	Family asks for restraints	Family education
	Wandering risk	Alarm system for resident in wrong place
	Staff believe restraints necessary	Staff education
Hip protectors for high risk residents	Too expensive	Second hand hip protectors
	Resident refuses to wear	Make them "hip"
No bed rails	New staff put them up, unaware of risk	Staff education, reminder signs
	Existing staff put them up by habit or because they don't believe that bed rails cause falls	Disable bed or tie them down, reminder signs
	Family put them up	Family information and education about the risk, reminder signs
Adequate lighting	Light bulbs burn out	Daily checks
	Lights turn off at night	Night lights in washroom or motion-activated lights