Work as a Team
Teamwork between DCS is also essential to falls prevention. Care staff should know which residents need assistance in ambulating, transferring, or simply standing. Any of these can result in a fall. To help prevent falls, never leave a resident alone during a transfer (bed to chair, wheelchair to toilet, etc.). When DCS work in a two-person team to provide more support for a resident during the transfer (two-person assist”), safety is further improved. All this requires team work. Team members need to know when another team member needs help. It is also advisable to educate all staff regarding residents who have mobility needs. This may prevent a well-meaning staff member from assisting a resident without full knowledge of what the assistance needs are.

Avoid Restraints and Alarms
ALF and RCF’s in Oregon are considered restraint-free environments (see OAR 411-054-0005 for the definition of restraint and 411-054-0060). Although in some cases it may seem that restraints or alarms could help keep a resident safe, the research shows that exactly the opposite is true. Using restraints and alarms do not help to prevent falls. In fact, these devices can actually cause falls when residents attempt to get out of them or slide down through them, or increase depression, increase agitation, or agitation in other residents who hear the associated noise. The alarms provide a clear example of an intervention that by attempting to prevent the risk of falling may actually increase the risk of serious injury from falling. They give a false sense of security and at the same time, absorb a great deal of staff time responding to the alarm and not the resident. In most cases the best way to prevent the risk of falls with injury is to promote the residents’ balance, endurance, and overall mobility. The first question staff should ask when a resident (especially one with dementia) who has an alarm that goes off is, “What does this resident need?” Often what will be stated to a resident is for them to “sit back down.”

Assessing and Decreasing Fall Risk
Clearly there are many people in LTC who are at risk for falls and injury and who need to have a safety plan in place. These plans need to be highly individualized and based on thorough evaluation of risk factors related to the person and his/her clinical condition, in the physician environment and the organizational environment. An important job for licensed nurses or other qualified staff is to assess or evaluation residents’ risk of falling. This is best done using a protocol or instrument that asks addresses or tests several features about the resident. Assessment and evaluation must be done in accordance with licensed professional’s scope of practice and or training.

The Hartford Institute for Geriatric Nursing recommends the Hendrich II Fall Risk Model, Other instruments include the Comprehensive Falls Risk Screening Instrument, the Falls Assessment portion of The Falls Management Program, the Vanderbilt Fall Prevention Program for Long-Term Care, and the Timed Up and Go Test. These and other resources are shown in the resource list at the end of this article.

Review a Checklist when doing evaluations/assessments—HEAR ME
Often, it is useful to have a mechanism to help you remember all of the things you need to think about. Here is a list of things to remember that fit into a handy memory aide: "HEAR ME." Remembering these "HEAR ME" tips can help you prevent falls in your nursing center.

- Hazards in the environment should be noticed and eliminated.
- Educate residents about how to accomplish their activities in a safe way.
• Anticipate the needs of residents. As you get to know your residents, you will learn their routines and habits and the times they will need your help. You can use that knowledge to "be there" almost before the residents know they need help.

• Round frequently to learn residents' needs. Rounding—going from patient to patient to see how they are doing—is the activity that lets you "keep an eye" on each of the residents and accommodate his or her needs in a timely way.

• Materials and equipment should be in working order, and they should be used correctly.

• Exercise and ambulation with residents is vital to maintaining their fitness and preventing falls. Occupational and physical therapy, if available, can be very helpful.

HEAR ME

• Hazards in the environment.
• Educate residents.
• Anticipate residents' needs.
• Round frequently.
• Materials and equipment.
• Exercises and ambulation.

Responding to a Near Fall or Fall
Everyone on the care team has a role to play in responding to a resident's near fall or fall. There are four steps to responding effectively.

1. Observe and evaluate. When you see that a resident has fallen, what do you observe? Is first aid or other additional care required? If so, your first priority is to make sure the resident gets that care as quickly as possible. Understand your community policies related to falls with injury or potential injury. You should always alert the attending professional (whether a licensed nurse, nurse practitioner, or doctor) according to the guidelines for notification that are the policy of your community.

2. Investigate and document. Once the resident's condition has been addressed, it is important to investigate the circumstances in which the fall took place. Try to notice and list everything that may have contributed to the fall, including the resident's individual risk factors, environmental factors, and factors in care or equipment. Be sure to ask the resident “What were you doing prior to the fall?” even residents with dementia. This can provide important information to understanding the root cause of the incident. Then you need to document what you have found. This should involve completing an incident report or falls investigation report.

The Oregon Falls Investigation Toolkit offers multiple resources on conducting falls investigations, root cause analysis can be found at http://oregonpatientsafety.org/healthcare-professionals/nursing-homes/long-term-care-falls-investigation-toolkit/284/

3. Implement an individualized care plan. Once the team reaches a conclusion about the causes of the resident's fall, an individualized approach for falls should be added to the resident's care plan. This approach may call for one or many interventions. If the falls continue, expand the problem solving team, potentially bringing in physical therapy, physician, brainstorming with other colleagues or staff in your organization, or by contacting OHCA.
An individualized service plan for falls is not a one-time solution. Staff must revisit the plan routinely to make sure it is effective in preventing additional falls and/or injuries from falls. If the plan is not effective, a new one should be devised.

4. Develop a falls management program. Beyond individualized service plans, communities can develop a falls management program aimed at falls prevention for the entire community. Staff should be documenting how many falls are occurring in a given time period and why those falls are occurring. With this information at hand, the team can design a menu of interventions and a process for individualizing interventions. Through tracking a community can see what is working and what is not working i.e. if the service plan intervention is use tab alarm and the falls are still occurring maybe something new should be attempted. One guideline to consider new approaches comes out of Stratis Health the Minnesota Quality Improvement Organization.

Many people would say well a resident falls because they are moving, but why is the resident moving, that’s the root cause. What we identified for the sake of simplicity was that residents generally had a need for one of the four P’s.

4 P’s
1. **Position**, they were sitting too long, lying on one side too long, they were getting restless and bored in their present surroundings so they had a need to move their position.
2. **Personal needs/Potty**
3. **Pain**, so they were becoming uncomfortable, aching and hurting, so they needed to move to relieve themselves of the pain.
4. **Placement** of their personal items, their glasses were out of reach, the tissue box or telephone, so it was the placement of a personal item that they were getting up for that led to them falling.

For more ideas refer to the Stratis Health document Effective Fall Prevention Strategies with Physical Restraints or Personal Alarms.

http://www.stratishealth.org/documents/TR_Effective_Fall_Prevention_20120424.pdf

**Resources**