Providing the highest possible quality of life and level of care to the residents makes resident safety a priority. Safety means avoiding, preventing, and lessening the effects of harm and injury. In reviewing the falls reporting with South Dakota Department of Health (DOH) online reporting for 6/8/18 through 7/8/18 there were 121 fall reports (falls with and without injury). The following is an analysis of those reports:

- Of the 121 reports there were 58 different facilities reporting.
    - Of the 58 facilities reporting, 42 were LTC and 16 were ALCs.
- Of the 121 reports, 81 were LTC residents, and 40 were ALC residents.
- There were 45 fractures reports.
    - Of the 45 fractures reported, there were 30 in LTC and 15 in ALC.
    - Of the Fractures reported, 20 were hip fractures.
        - Of the 20 hip fractures reported, 13 were LTC residents and 7 were ALC residents.

DOH has created a flow diagram to assist when to and when not to report a fall. This is to be used in **combination** with the other flow diagram of *Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime*.

Falls often have serious consequences. They decrease the resident's quality of life and ability to function. After falling once, a lot of times residents will self-impose activity limitations on themselves.
Falls are usually a combination of risk factors, both intrinsic and extrinsic. Agency for Healthcare Research and Quality (AHRQ) identifies these factors as:
Intrinsic:

- Effects of aging on gait, balance, and strength
- Acute medical conditions
- Chronic diseases
- Deconditioning from inactivity
- Behavioral symptoms and unsafe behaviors
- Medication side effects

Extrinsic:

- Environmental hazards
    - Poor lighting; Cluttered living space; Uneven floors, wet areas
- Unsafe equipment
    - Unstable furniture; Ineffective wheelchair brakes, Missing equipment parts
- Unsafe personal care items
    - Improper footwear; Hard to manage clothing; Inaccessible personal items.

A culture of safety has to be developed throughout the entire organizational system. This includes staff attitudes, beliefs, and behaviors with falls. Encouragement to report all the details of an unsafe condition needs to be developed. No one should be "blamed or shamed" with a fall. The system should view the fall as a team approach to make improvements for quality of care of all the residents within the facility. Strong leadership is essential in establishing this safety culture.

When reporting a fall, make sure interventions are implemented to prevent the fall from reoccurring. **All residents should be assessed before trying any of the new interventions to ensure it is not a restraint.** Every intervention should be specific to the individual. Below is a sample listings of interventions that have been compiled from a variety of sources, this is not an all-inclusive list.

Person ideas:
Pain – assess and care plan/treat
Shoes – too big or small – what are the soles like
Gripper socks
Adhesive strips by bed/chair
Toileting schedule – track schedule for 3 days to determine individualized plan
Hourly (or more frequent rounds) - Teach staff what to check for when they round.
Reposition more frequently
Are they hungry or thirsty? Have snacks by bed or offer assistance as needed.
Correct environment – is it too chaotic or loud?
Correct room placement (within the room or within the hallway)?
Activities such as: gross muscle activities (bowling, ring toss, etc.)
1:1's
Music – with or without headphones
T.V. – Appropriate channel/volume/placement to see
Photo frames with moving pictures or photo books
Videos of family members that can be played on the television
Skype with family/friends
Virtual Reality
Pet therapy
Dolls or other lifelike objects
Outside walks
Sensory lights
Books on tape
Fidget spinners
Weighted blanket for comfort or to reduce anxiety
Warmed blanket for comfort or to reduce anxiety
Clothing – too tight, loose, or too long
Kinetic energy balls pendulum
Medication changes
Medication review
Orthostatic B/P – especially if on blood pressure medicines
Blood sugars

Equipment:
Appropriate walker/cane (type of wheels/tip)
Wheelchair placement - by bed or recliner
Items within reach
-drinks, call light, phone, snacks, T.V. remote, reacher, lift chair remote out of reach or within reach (depending on cognition)
Mattress
-lip mattress to define edge (be careful it is not a restraint)
-bedding too slippery
Bed wheels locked
High low bed
Grab bars/Assist rail (ensure appropriate order, assessment, etc.)
Bed remote in correct location
Night light
Motion sensor to alert staff
Commode at night by bed

Tilted mirrors
Rocker wheelchair
Wheelchair bag or tray to keep items close
Cup holder on wheel chair
Foot pedals

Room ideas:
Room arrangement
Room lighting – night light
-they can see hallway if they like
-bed placement
--which side is easier for them to get up
-bed at the correct height
Room clutter
Floor slippery – skid strips
Room closer to nurses' area or staff foot traffic
Door open or closed per needs/likes/dislikes
Curtains opened or closed depending on need
Recliner is appropriate for person – material type, size, etc.

Facility:
Outdoor walking path
Interactive wall hangings
Puzzle tables
Activity stations
Ensure chairs are sturdy for those who use them as balance supports when walking
Lobby chairs – slippery material

Physical Abilities:
Recent illnesses
Glasses on and clean
Eye exam
Hearing check – equilibrium
Restorative therapy program review
OT evaluation
Wheelchair positioning
PT evaluation
Podiatry exam
UTI - precautions – extra fluids – test for if appropriate
Chair exercises before meals
Group exercise programs
Balancing programs

An inappropriate intervention that is frequently seen is," remind resident to use the call light." When the resident's BIMS is reviewed, it reveals they have a score of 03. They will not remember to use the call light. They will need another type of cueing.

Also, a root cause needs to be determined with the investigation. A good way to determine a root cause is to ask "why" five times. Example: Resident has a fall in the hallway, why? Improper footwear, why? Shoes are in the closet, why? Shoes are too tight and causing red areas, why?

Resident's legs are swollen and had a recent weight gain, why? Exacerbation of CHF. Resident on new medication, diuretic, needs more frequent toileting after medication given for next 2 hours. Care givers and care plan updated.

Here is an example of a complete falls report.

Initial report:
On (date) at 6:30am, the charge nurse was called to the Alzheimer's Care Unit by CNA and found resident sitting on the side of his bed with dried blood all over hands and face and head. The charge nurse asked resident, what happened and he said he fell backwards a long time ago. Resident's diagnoses include: (list of diagnoses). Resident was immediately assessed: T 98.0, P 84, R 18, B/P 157/85 and O2 SATS 93% on room air. Resident has laceration on right side of head measuring 3.4 cm long and .2.3 cm deep with a bump surrounding the laceration. Laceration by right eye 1 cm long, scrape on right shoulder 1 cm x .3 cm dry and intact, also a bruise on inside of left hand 4.5 cm x 2 cm. Resident sent to ER.

Final (5 day) report:
Resident sent to ER and received 4 sutures on right side of head and CT scan done which was negative. Resident returned from the ER, we are to monitor sutures for s/s infection; we are to apply bacitracin or triple antibiotic ointment to the sutures daily and resident to have follow-up in 3-4 days with provider on rounds at facility for suture removal. Wife notified of incident and states understanding.

Investigation reveals:
C.N.A. states that at 3:30am on (date), resident was up and she gave him something to eat and that around 4:00am resident went to his room and went back to bed. When resident was found in bed at approx. 6:30am, there was noted urine on the bathroom floor. Resident is able to ambulate and toilet independently. Resident post fall assessment on (date) is as follows: BP: 128/63, P: 78, T: 94.4 R: 18. Temperature was attempted a couple times and got the same reading. Resident did pull away. PERRLA No nonverbal indicators of pain noted. Resident moves extremities per normal self. Resident is alert but disoriented per norm. Hand grasps equal and strong. No seizure like activity noted or episodes of vomiting. Sutures are intact no s/sx infection noted. Monitoring will continue. Alzheimer's Care Director(ACD) and DON reviewed psychotropic medications. New intervention: Medications reviewed and it was noted patient's Seroquel was increased to 75mg bid from 50mg bid due to aggressive behaviors on (date) and Ativan 0.5mg BID was initiated on (date). Resident has had three falls since Seroquel was increased. DON and ACD spoke with Dr. ordered to decrease Seroquel to 50mg po bid and continue scheduled Ativan as ordered.